

Student: _____ Date of Birth: _____
Last First M.I.

Grade: _____ Class: _____ Home Address: _____

Parent Authorization for Emergency Medical Treatment
Emergency Contact and Medical Information

◆ **Emergency Contact Information:**

Parent/Legal Guardian Home Phone Work Phone Cell/Pager/Other

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If parent or legal guardian cannot be reached, please contact:

Name Telephone Relationship

Family Physician: _____ Phone: _____

I prefer that my child be sent to _____ for medical care.
(Hospital/Medical Facility)

Please specify and describe any health conditions and physical or other health impairments that we should know about:

Medication(s) needed:

Restrictions:

◆ **Medical Insurance Information:**

Name of Medical Plan: _____ Policy No.: _____

Subscriber's Name: _____ Subscriber No.: _____

In case of medical or surgical emergency pertaining to the above-named student and after reasonable efforts to contact me or my spouse (or other legal guardian) have failed, I hereby give my permission to The Hawaii Japanese School to select those qualified physicians whose emergency, medical or surgical assistance is reasonably necessary under the circumstances. I also hereby give my permission to such qualified physicians and/or surgeons selected by The Hawaii Japanese School to provide whatever emergency medical treatment is necessary under the circumstances.

This authorization is valid from April 3, 2010 to March 12, 2011

Signature of Parent/Legal Guardian Date

Please return your completed form to the Business Office by January 10, 2010

PLEASE NOTIFY THE SCHOOL PROMPTLY OF ANY CHANGE IN THE ABOVE INFORMATION

Revised April 2010