

MEDICAL AUTHORIZATION FOR TREATMENT OF OUR CHILD

We, the undersigned, re the parents/guardians of the following child and because of our anticipated absence we hereby appoint Carlisle School or it's representative to be the temporary guardian of our child. We confer upon the temporary guardian the authority to sign on our behalf any and all medical and dental treatment contracts and treatment authorization forms without limitation, which the guardian deems necessary for the benefit of our child in the event of illness or injury. We agree to pay for all such treatment and to save the guardian harmless from these expenses. The following information is provided to assist the health care provider and is declared by us to be accurate:

Name of Child: _____
Last First Middle.

Date of Birth: _____ S.S.#: _____

Allergies: _____

Current Medications: _____

Existing Medical Problems: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Primary Guardian: _____ Work Phone: _____
Last First M.I.

Home Phone: _____ Cell Phone: _____

Other Phone: _____ Email Address: _____
(No student email address, please)

Mailing Address: _____

Other Guardian: _____ Work Phone: _____
Last First M.I.

Home Phone: _____ Cell Phone: _____

Other Phone: _____ Email Address: _____
(No student email address, please)

Mailing Address: _____

Alternate Emergency Contact: _____

Insurance Company: _____

Policy #: _____ Group Plan #: _____

Policy Holder: _____ Relationship: _____

Guardian 1 Signature Date Relationship

Guardian 2 Signature Date Relationship