The Cooper School

EMERGENCY CARD & MEDICAL RELEASE FORM

Child's Legal Name (Last, first, middle initial) _____ Birth Date _____ Age _____ Gender _____

Child's Home Address _____ City, Zip _____ Home Phone _____

Mother's Name (or Legal Guardian) _____ Home Phone Number _____ Cell Phone Number _____

Mother's Home address (if different from child) _____ City, Zip _____ Mother's Employer _____ Work Phone Number _____

Father's Name (or Legal Guardian) _____ Home Phone Number _____ Cell Phone Number _____

Father's Home address (if different from child) _____ City, Zip _____ Father's Employer _____ Work Phone Number _____

Student Resides with:

☐ Mother & Father ☐ Mother ☐ Father ☐ Joint Physical Custody ☐ Other:_____

☐ *Court Order prohibits the release of child to*_____*(copy **must** be on file at school)*

Please list any health problems, allergies, special problems or conditions that we need to be aware of (please attach a list if necessary): _____

_____

_____

Name of child's physician: _____ Phone_____

Name of child's dentist: _____ Phone_____

In case child listed above becomes ill or is injured at school and parents cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Additional persons allowed to pick up child from school: (we will not release child to any other person)

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

I, the parent or guardian of the above named child, hereby give consent to and authorize any medical doctor or dentist and others working under their supervision to treat my child for any injury or illness. I further agree to pay any and all such dental and medical costs, expenses and charges and to release and discharge and hold harmless The Cooper School, its employees and agents from and against any liability or any claim or demand arising from or connected with such medical treatment or care.

_____ _____

Parent or Guardian Signature Date