



**Steward Elementary School #220
602 Main Street, P.O. Box 76
Steward, IL 60553**

Lowell Taylor
Superintendent/Principal

**Medical Authorization Form
2016 – 2017**

STUDENT:		DATE OF BIRTH:	
SPORT / ACTIVITY:	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Basketball	<input type="checkbox"/> Cheerleading <input type="checkbox"/> Track
	<input type="checkbox"/> Other _____		
HOME ADDRESS:		HOME PHONE:	

To Whom It May Concern: **In the event reasonable attempts to contact me at the locations listed below are unsuccessful, I, as the parent or legal guardian of the above named student do hereby authorize (1.) the treatment by a qualified and licensed medical doctor of my student in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed; and (2.) the transfer of my student to any hospital reasonably accessible. This release is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.**

PARENT(S)/GUARDIAN(S) NAME(S): <i>(please print)</i>		RELATION TO STUDENT:	
HOME ADDRESS:		HOME PHONE:	

EMERGENCY CONTACT: <i>(please print)</i>			
HOME PHONE:		BUSINESS PHONE:	
PHYSICIAN'S NAME(S): <i>(please print)</i>		PHYSICIAN'S PHONE:	

Please list specific medical allergies, medicines, and/or other conditions – attach additional sheet(s) if necessary:

Parent / Guardian Signature

Date