

MEDICAL RELEASE AUTHORIZATION
Please print clearly.

I, _____, authorize the Extended Day Director and/or Extended Day staff to administer first aid and/or seek medical assistance in the event of an emergency.

Child's name: _____ Date of birth: _____

Address: _____

Town: _____ State: _____ Zip: _____

Emergency Contact Information

Call first:

Name _____ Relationship _____

Address: _____

Home: _____ Work: _____ Cell: _____

Call second:

Name _____ Relationship _____

Address: _____

Home: _____ Work: _____ Cell: _____

Insurance Information

Insurance Company: _____

Policy # _____

Please list all current allergies and medications, include dosages and usual time administered

Parent or Guardian signature: _____

Parent or Guardian Printed Name: _____ Date _____

This authorization is valid for the entire school year of 20____ to 20____