Edgemont School District –Emergency Medical Authorization

PO Box 29 Edgemont SD 57735 605-662-7254

Student Name _____Date of Birth _____Grade_____

Mailing Address_____Street Address _____

Home Telephone _____

Father's Name _____Work Phone/cell phone _____

Mother's Name _____ Work Phone/cell phone_____

CONSENT FOR MEDICAL TREATMENT

I am the_____ (Mother-Father-Legal Guardian)

of _____, who participates in school sponsored/co-curricular activities for Edgemont School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of Edgemont School while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this_____day of_____ , year_____

Parent's Signature: _____

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Insurance Carrier_____Policy Number_____

** School Messenger the school's telephone broadcast system that enables the school to notify all households by phone within minutes of an emergency or unplanned event that causes early dismissal, school cancellation or late start. The service may also be used to communicate general announcements or reminders. PLEASE INDICATE BELOW THE NUMBER YOU WOULD LIKE TO BE CONTACTED ON. *(RETURNING FAMILIES-ONLY FILL OUT IF THE NUMBER HAS CHANGED FROM LAST SCHOOL YEAR)*

SCHOOL MESSENGER contact number(s) _____ _____

Emergency/Storm Numbers: Who we may contact if parents are not reachable:

Name _____ Phone # _____ Street Address _____

Name _____ Phone # _____ Street Address _____