

EMERGENCY MEDICAL TREATMENT

(Release)

In the event of an emergency, I hereby give permission to The Clear View School of Westchester to obtain medical and surgical treatment of my child_____. I authorize transportation to a hospital, where required, and treatment by a physician or surgeon selected by the School in the event that should be deemed necessary. I agree to assume responsibility for all charges so incurred.

Please indicate any information that should be available to an emergency physician (allergies, medication, etc.).

Medical Insurance Carrier: _____

Policy Number: _____

Medicaid Number: _____

Social Security Number: _____

Signature of Self
(Age 18 or older)

(Parent or Guardian)

Date