PARENT AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Heritage Academy
12215 Walnut Point West
Hagerstown, MD. 21740
(301)582-2600

Student's Name: _____ Date of Birth: _____ Age: ____

Any known allergies or pre-existing conditions:

_____

_____

***Current prescription medication(s): _____

(PMOF's are required for all prescriptions and non-prescription medicines)

Custodial Parent: Name: _____

Address:_____

Daytime Phone #: _____ Evening Phone #: _____

Health Insurance Co: _____ Policy #: _____

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Heritage Academy personnel to hospitalize, secure proper treatment for, and order injection, or surgery for my child as named above.

Date: _____ Parent Signature: _____

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****All regular medications (with PMOF's) are to be carried and dispensed by Heritage Academy personnel if the student's parent is not present.****

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