EMERGENCY RELEASE FORM

Teacher ____________________

Name: ____ Birth date___________________
(last) (first)

Home Address ____ Home Phone __________________

Father's name____ Work Phone___________________

Mother's name ____ Work Phone __________________

Child is living with:

☐both parents ☐mother only ☐father only ☐other (name)________________________________

Siblings attending West Jordan Elementary School:

Name	Grade	Teacher

In the event of an earthquake, making phone calls within the city may be difficult, but calling to someone out of state would be possible. If you have a relative living out of state who could receive a message about your child, please fill out below:

____ ___________________ ____________________
(name) (relationship) (area code and phone #)

Please list the names of the people who are authorized to pick up and transport your child in the case of a personal emergency or community disaster. List people who live within walking distance of the school, are usually at home, and willing to care for your child until you can be reunited.
NOTE: IT IS IMPORTANT TO NOTIFY THESE PEOPLE WHO ARE LISTED BELOW

NAME	ADDRESS	PHONE	RELATIONSHIP

I HEREBY AUTHORIZE WEST JORDAN ELEMENTARY SCHOOL TO RELEASE MY CHILD TO ANY OF THE ABOVE PERSONS IF I AM NOT AVAILABLE.

Parent/Guardian signature: ____ Date ____________

AUTHORIZATION OF CONSENT
FOR MEDICAL TREATMENT OF A MINOR CHILD

I/We ______________________________ (and) __________________________________

In the city of __________________________, county of ____________________________

Do hereby state that I am (we are) the parent/s or legal guardian/s, having legal custody of

____________________________________, age ___________ birth date ___________
(child's full name)

who resides with me at ____
(address) (city) (state)

I/We authorize Norman Emerson, principal, or her designee, an adult at West Jordan Elementary School at 7220 South 2370 West, West Jordan, Utah 84084, 801-565-7506 to consent to an x-ray, examination, anesthetic, medical or surgical diagnosis for treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of Utah when the need for such treatment is immediate, and when efforts to contact me/us are unsuccessful. I/We agree
to assume all financial responsibility for the services provided my child. This authorization is to be effective upon the date of an occurrence unless revoked by me/us in writing. Either parents/guardian's death or disability shall not affect this authorization.

Signature/s of parent/s or guardian/s:

____ Date: ___________________

____ Date: ___________________

The following information could be vital to emergency medical care personnel in case of a community disaster:

Child's Doctor ____ Phone # ________________

Health Insurance Company ______________________________ Group # ________________

Does your child have a chronic illness? ☐yes ☐ no If yes, explain ____________________

Does your child have asthma? ☐ yes ☐ no

Does your child have allergies? ☐ yes ☐ no If yes, please list ________________________

Is your child allergic to medication? ☐ yes ☐ no If yes, please list _____________________

Is your child presently taking medication? ☐yes ☐ no If yes, list _____________________