Green Bay Trinity Lutheran School
Authorization for Emergency Transportation and Treatment

Student's Name _____

Last First MI

Allergies _____

Medications _____Contacts? Y / N

Father's Full Name: _____Employment _____

Home Phone _____Work Phone _____Emergency Phone _____

Mother's Full Name: _____Employment _____

Home Phone _____Work Phone _____Emergency Phone _____

Insurance Company _____ Insurance ID: _____

Family Doctor _____Phone Number _____

Family Dentist _____ Phone Number _____

Hospital Preference (if applicable) _____

1. I authorize school personnel to transport the above-named student to a physician's office and/or the emergency room for treatment in the event that emergency medical care is needed while he/she is involved in extracurricular activities. Further, I authorize the physician and hospital staff to treat the above-named student as they deem necessary in an emergency.
2. In accordance with HIPPA, I authorize health care providers of the above-named student, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to the appropriate school personnel, such as but not limited to: the Principal, Athletic Director, Athletic Trainer, Team Coach, and other health care providers for purposes of treatment, emergency care, and injury record keeping.

Parent/Guardian Signature _____Date _____