



L'Ecole Française du Maine

Emergency / Student Health / Medical Release Form

This form is required for all students and may be modified at any time throughout the year

Child's Name: _____ Date of Birth: _____ Grade: _____

First scheduled day of school at L'Ecole: _____

Student lives with both parents (one household) ☐ both parents (two households) ☐ mother ☐ father ☐ other ☐

Parent Guardian's Name and Home mailing address:

Place of Employment/Daytime Address:

Email address: _____

Home phone: _____

Cell Phone: _____

Work Phone: _____

Beeper: _____

Parent Guardian's Name and Home mailing address:

Place of Employment/Daytime Address:

Email address: _____

Home phone: _____

Cell Phone: _____

Work Phone: _____

Beeper: _____

PLEASE LIST TWO PEOPLE WHO CAN BE CONTACTED IN CASE OF AN EMERGENCY IF A PARENT/GUARDIAN CANNOT BE REACHED. A CONTACT PERSON SHOULD BE SOMEONE WHO IS READILY AVAILABLE.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please list anyone you give permission to pick up your child at school and indicate dates this permission is valid.
Please initial this authorization next to each name listed.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

FORM CONTINUED ON OTHER SIDE

PEDIATRICIAN/ FAMILY DOCTOR AND DENTIST

Doctor's Name: _____ Phone: _____ Address: _____
Dentist's Name: _____ Phone: _____ Address: _____

MEDICAL INSURANCE

Insurance Company _____
Policy Holder _____
Policy Number _____ Group Number _____

MEDICAL INFORMATION

Medication(s) your child is allergic to: _____
Medication (s) your child is currently taking: _____
Allergies: _____

If your child has a medical condition, such as asthma, please describe:

Other information you would like us to have:

MEDICAL EMERGENCY AUTHORIZATION

I/WE _____

THE PARENTS OF _____

Hereby acknowledge:

I/We may not be available to provide consent for medical treatment in the event that our child becomes sick or is injured during participation in a school authorized activity. If I/we are not available for such consent, it is my/our desire to have the best available medical treatment for my/our child. This form hereby authorizes L'Ecole Française du Maine and its staff to act on my/our behalf with respect to any required medical treatment decisions and consents until such time as I/we are able to provide these items. Notice is hereby given to any qualified medical personnel that this authorization is currently in effect and such personnel are directed to act upon such authorization without delay. I/We agree to assume financial responsibility for all expenses and bills incurred in any emergency requiring medical attention. The School has my permission to release and share relevant medical information with school staff, emergency medical personnel, the hospital, my child's doctor and health insurer for the purposes of safety, referral, diagnosis, and/or treatment.

The School may continue to rely on this authorization and consent unless and until I notify the School in Writing.

Parent/ Guardian Signature (s) _____

Date: _____