Mount Prospect School District 57

Authorization for Medical Treatment

To be submitted to the school front office. (Please print.)

Student	All Interscholastic Athletics
Parent/Guardian	Home Phone
Home Address	Cell Phone
City, State Zip	
Physician	Physician Phone

Medical Information: (List allergies, medications, conditions and any known restrictions.)

In the event of a medical emergency and if reasonable attempts to contact me using the telephone numbers listed above are unsuccessful:
I, as parent or legal guardian of the above student, do hereby authorize:

1. Treatment by a licensed medical physician of my child/ward in the event of a medical emergency that, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and
2. Transfer of my child/ward to any hospital reasonably accessible at my expense.

Parent/Guardian Signature	Date