SCHODACK CENTRAL SCHOOL DISTRICT
MEDICAL TREATMENT RELEASE FORM

PLEASE PRINT

_____

(Name of Student)

is a student in the Schodack Central School District attending the

_____

(Destination)

on _____
(Date)

In the event that I am unreachable during an emergency involving my child, I hereby give permission to the supervising teacher to act on my behalf and to authorize whatever medical procedures are deemed necessary to protect the health and safety of my child, until such time as I may be reached.

_____

(Name of Parent/Guardian - Please Print)

_____ _____

(Signature of Parent/Guardian) **(Date)**

Phone Numbers: Home: _____

Work: _____

Cell: _____