

Addison Park District

Emergency Treatment Release

As a parent and or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor or practitioner of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me.

Any expenses incurred will be the responsibility of the child's family.

Name of minor \_\_\_\_\_

Birth date \_\_\_\_\_ Relationship (son or daughter) \_\_\_\_\_

Date or dates when release is intended during regular school day. This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Please fill in immunization information - include **All dates of all shots.**

Shot	Month/Date/Year				
	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
Diphtheria, Pertussis & Tetanus (DPT)					
DT					
Oral Polio					
HBCV (Hib)					
Combined Measles/Mumps/Rubella MMR					
Rubeola (Red Measles) Live virus vaccine					
Rubella ( 3 day or German Measles					
Mumps					
TB Skin Test Results					
Hepatitis B					