The Vanguard Academy
Medical Release and Authorized Pick Up
2018-19

Student Name	Date of Birth

Parent 1	
Address	City
State	Zip
Employer	Phone
Email	Cell

Parent 1		
Address	City	
State	Zip	
Employer	Phone	
Email	Cell	

Authorized Pick Up

Name	Phone
Name	Phone
Name	Phone
Name	Phone

Medical Information

Hospital Preference:	
Pediatrician Name:	Phone
Insurance Company:	Policy Number:
Allergies/ Special Health Considerations	
Known Medical conditions, seizures etc....	

Does your child possess an Epi Pin? ________ If so, please give this to the school office in its original box

Consent Signature:

I authorize all medical and surgical treatment, x-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be preformed or prescribed by the attending physician, and or paramedics for my child and waive the right to informed consent of treatment. The waiver applies only if neither parent and/or guardian can be reached in the case of emergency, ______________________________

Parent/Guardian Signature: ____ **Date:** ____________________

Parent/Guardian Signature: ____ **Date:** ____________________