# EMERGENCY MEDICAL RELEASE

Casa dei Montessori
7646 Hwy. 70 S.
Nashville, TN 37221
(615) 673-8000

Student Name_____
Address_____
Phone_____

**Purpose** To enable parents and guardians to authorize the provision of first aid and emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**MUST BE COMPLETED AND NOTORIZED**
**TO GRANT CONSENT**

In the event reasonable attempts to contact me at _____(phone number) or (other parent or guardian)_____at _____(phone number) or (friend or relative) _____ at _____(phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr._____ (preferred physician) _____(phone), or Dr._____(preferred dentist) _____(phone), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonable accessible.

---

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted:

_____

_____

_____ _____

Date Signature of Parent or Guardian

_____

Address