Home Educators for Excellence
Medical Release & Health Information
Authorization for treatment of minors for the year 2009-2010

The undersigned, being the parent or legal guardian of the following children:
(Please list any/ALL children who may be present at co-op whether they are or are not participating in classes.)

_____, a minor, born on _____;

_____, a minor, born on _____;

_____, a minor, born on _____;

_____, a minor, born on _____;

_____, a minor, born on _____;

_____, a minor, born on _____;

_____, a minor, born on _____;

request and authorize any physician, associates, assistants, agents and employees thereof, to provide any x-ray, examinations, anesthetic, diagnosis, medical, or surgical treatment, or hospital or clinic service that may be required by said minor in the estimation of such physician, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understand that this authorization is given in advance of any specific diagnosis or required treatment and is given to encourage said hospital and said physicians to exercise their best judgment as to the requirements of such diagnosis and treatment in those instances when a parent of the minor is unavailable to provide the necessary consent to treatment.

This authorization is valid from:

_____ _____ _____
Signature of parent/guardian | Print name of parent/guardian | date

Please list any allergies (latex, peanuts, dairy etc.) and medications (inhaler, epi-pen) your children have:
(if your child/ren do not have allergies or special needs, please write NONE in the blanks provided)

Name	Allergy	Medication
Name	Allergy	Medication
Name	Allergy	Medication
Name	Allergy	Medication
Name	Allergy	Medication

Please describe any other medical conditions/special needs which you want instructors aware of:

Name	Condition/special need
Name	Condition/special need
Name	Condition/special need