Canisius High School Emergency Medical Authorization

Student Name: __________________________________________

I hereby give my permission for my/our son to participate in the Higher Achievement Program. I have reviewed the application with him and agree with the policies.

By permitting my son to participate, I/we expect reasonable and adequate supervision of my/our son. It is thus agreed that I/we will hold Canisius High School and its agents harmless from all liability and all legal proceedings arising during the program, unless caused by or due to the gross negligence of either Canisius High School or its agents.

I hereby grant permission for Canisius High School to obtain medical care from a licensed physician, hospital, or medical clinic for my son in the event that I cannot be contacted.

Physician’s name: ________________________________   Physician’s phone number: __________________

Dentist’s name: ________________________________   Dentist’s phone number: __________________

Medical Insurance: ________________________________   Medical Insurance Policy Number: ____________

Medical Insurance Holder’s Name: ________________________________

List Pertinent Medical Facts (allergies, physical impairments, etc): ______________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Emergency contact if parent/guardian cannot be reached:

Name: ________________________________   Phone Number: ________________________________

I give permission to inform my/our son’s teacher of pertinent health information:   YES   NO

I give permission for my/our son to receive necessary medication/treatment as prescribed by the medical director or supervising adult:   YES   NO

___________________________________________   __________________________
Parent/Guardian Signature   Date