**School District of Haverford Township**
**Haverford Middle School**
**1701 Darby Road**
**Havertown, PA 19083**
**(610) 853-5900**

**PARENTAL CONSENT FORM FOR MEDICAL TREATMENT**

With the increasing sophistication of our medical systems, we are finding it necessary to have parental permission and release forms in the unlikely event of some serious injury requiring medical treatment.

This release gives us permission to take your child to the nearest available medical facility and have the necessary treatment administered. This SIGNED FORM is necessary since many hospitals will not administer any medical attention to a minor without some parental consent. Therefore, please read the statement (in capital letters) and add your signature to the bottom of the form.

**IN CASE OF EMERGENCY, I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME. IF I CANNOT BE REACHED, I HEREBY GIVE HAVERFORD SCHOOL DISTRICT, AND THOSE INDIVIDUALS ACTING ON BEHALF OF THE DISTRICT, THE PERMISSION TO ACT ON MY BEHALF IN SEEKING EMERGENCY TREATMENT FOR MY CHILD _____ IN THE EVENT THAT SUCH TREATMENT IS DEEMED NECESSARY BY THE HAVERFORD SCHOOL DISTRICT STAFF, VOLUNTEERS OR COUNSELORS. I GIVE PERMISSION TO THOSE ADMINISTERING EMERGENCY TREATMENT TO DO SO, USING THOSE MEASURES DEEMED NECESSARY. I ABSOLVE HAVERFORD SCHOOL DISTRICT, STAFF, VOLUNTEERS AND COUNSELORS FROM LIABILITY BY ACTING ON MY BEHALF IN THIS REGARD.**

## Medical Release Form

**I _____ authorize the Haverford Middle School**
**(Parent/Guardian Printed Name)**

**Assistant Principal, Mr. Matthew Crater and or any other designated Haverford Middle School staff member to receive and disclose health treatment information from/with Pocono Medical Center for: _____.**
**(Child's Printed Name)**

**Parent Signature: _____ Date: _____**

**Home Phone: _____ Cell Phone: _____**

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***For official use only:***
**Witness/Staff signature: _____ Date: _____**