



# The Vanguard Academy Medical Release and Authorized Pick Up 2024-25

<b>Student Name</b>	<b>Date of Birth</b>
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<b>Parent 1</b>	
<b>Address</b>	<b>City</b>
<b>State</b>	<b>Zip</b>
<b>Employer</b>	<b>Phone</b>
<b>Email</b>	<b>Cell</b>

<b>Parent 1</b>		
<b>Address</b>	<b>City</b>	
<b>State</b>	<b>Zip</b>	
<b>Employer</b>	<b>Phone</b>	
<b>Email</b>	<b>Cell</b>	

### Authorized and Emergency 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 performed or prescribed by the attending physician, and or paramedics for my child and waive the right to informed consent of treatment.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_