



SOUTHERN WESTCHESTER BOCES

BOARD OF COOPERATIVE EDUCATIONAL SERVICES

PLEASE SIGN AND DATE **EMERGENCY MEDICAL RELEASE**

In the event of an emergency, I understand that every attempt will be made to contact me. Should BOCES be unable to reach a parent/guardian, I hereby give permission to BOCES Southern Westchester to obtain medical and surgical treatment as necessary, for my child.

Name of Student (please print)

I authorize transportation to a hospital, when required, and treatment by a physician or surgeon selected by the hospital. I authorize the exchange of all pertinent information between the hospital and BOCES Southern Westchester and my child's Intermediate Care Facility (as applicable).

Furthermore, I understand that my child's Intermediate Care Facility (as applicable) will be notified immediately.

Signature of Parent/Guardian

Date

Home phone #

Work Phone #

Other Emergency Phone #

E-Mail Address

Emergency Contact other than parents:

Name

Relationship to Student

Phone Number

Alternate Number

Name

Relationship to Student