

# WILLOW CREEK PUBLIC SCHOOLS

PO Box 189, Willow Creek, MT 59760

Elementary School  
PO Box 189  
Ph: (406) 285-6991  
Fax: (406) 285-6923

High School  
PO Box 189  
Ph: (406) 285-6991  
Fax: (406) 285-6923

## MEDICAL RELEASE AND RESPONSIBILITY

(To be completed by Parent/Guardian)

Name of Student(s): 1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

Grade Level(s): 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

### A. PARENTAL RELEASE FOR MEDICAL CARE

1. I, \_\_\_\_\_, authorize employees of Willow Creek School District No. 15, J15 – 17: facility and staff members, coaches, advisors, or administration in charge of students to obtain all necessary medical care and authorize any licensed physician and/or medical personnel to render treatment to my son(s)/daughter(s): \_\_\_\_\_

\_\_\_\_\_

Parent Signature

Date

### B. EMERGENCY CONTACT INFORMATION

1. In the case of an emergency and if a parent/guardian cannot be reached, the following people can be contacted:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

**This information is required and must be filled in before it will be accepted in the office. All students enrolled are required to have this form on file in the H.S. or Elementary Office.**

Parent's/Guardian's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Physical/Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_ Group Name: \_\_\_\_\_

Group I.D. # \_\_\_\_\_ or Employee I.D. Number: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

\_\_\_\_\_

City

State

Zip