Emergency Medical Release Form

Kauai Academy of Creative Arts
PO Box 481
Lihue, HI 96766
(808) 634-9850

Student Name: _____ Home Telephone: _____ Age: ___

Current Allergy or Medical Information:

_____

_____

Mother/Guardian: _____ Cell Phone #: _____

Father/Guardian: _____ Cell Phone #: _____

Physician's Name: _____ Business Phone: _____

Insurance Company:_____ I.D No. _____

Names of two persons to contact if parent/guardian cannot be reached:

Contact #1 Name:_____ Daytime Phone: _____

Contact #2 Name:_____ Daytime Phone: _____

In case of a medical emergency, I understand that every effort will be made to contact parents or guardians of the student. In the event that I cannot be reached, I hereby give my permission to the administration of Kauai Academy of Creative Arts to secure the services of a licensed physician, for the emergency treatment of my child as named above.

_____ _____

(Signature of parent/legal guardian) (Date)