EMERGENCY MEDICAL FORM

Student Information Date: ___ /___ / ____

Student Name: _____ Birthdate: ___ /___ /____ School: _____

Address: _____ Home Phone: _____ Cell Phone: _____

_____

Parents' Names: _____

Doctor: _____ Phone: _____

Local Hospital: _____ Phone: _____

Ambulance: _____ Phone: _____

Please list any information concerning the child's medical history, including allergies, medications being taken and any physical impairments.

_____

_____

_____

Telephone Numbers (of authorized persons to contact if your child is ill or injured)

1st Contact: _____ Relationship:_____ Phone: _____

2nd Contact: _____ Relationship:_____ Phone: _____

3rd Contact: _____ Relationship:_____ Phone: _____

4th Contact: _____ Relationship:_____ Phone: _____

Emergency Medical Authorization

_____ YES, I authorize consent for emergency medical treatment

_____ NO, I DO NOT authorize consent for emergency medical treatment

Emergency Surgery Authorization

_____ YES, I authorize consent for emergency surgery following two opinions

_____ NO, I DO NOT authorize consent for emergency surgery following two opinions

_____

Signature of Parent or Guardian