Emergency Medical Form

_____
parent signature

STUDENT INFORMATION:

STUDENTS NAME _____ Age _____
Last First Middle

HOME TELEPHONE: ( ) _____ Date of Birth _____

ADDRESS _____ PARENTS NAME (S)_____
Street

_____ CONTACT INFO _____
City State Zip

PERSON TO CONTACT IF UNABLE TO REACH PARENT/GUARDIAN:

NAME _____ RELATION TO STUDENT _____

HOME PHONE NUMBER _____ WORK PHONE NUMBER _____

ALLERGIES to MEDICINE (or Drugs):_____

PAST PERTINENT OR CURRENT MEDICAL CONDITIONS or MEDICAL DIAGNOSIS:

_____

MEDICATIONS:

Name of Medication	Dosage	Time of Day
_____	_____	_____
_____	_____	_____

DATE OF LAST TETANUS _____ **CONTACTS WORN?** Y N (Hard Soft)

FAMILY PHYSICIAN _____ PHONE _____

FAMILY DENTIST _____ PHONE _____

---------- Please read and sign ONE of the two lines ----------

To Grant Consent for Treatment

I hereby give my consent, in the event that all reasonable attempts made to contact me at my home or my place of employment have been unsuccessful, for the administration of treatment deemed necessary by a licensed physician or dentist, and the transfer to any hospital or emergency care facility reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE_____

REFUSAL To Consent:

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:

SIGNATURE OF PARENT/GUARDIAN: _____ DATE_____