MEDICAL INFORMATION & AUTHORIZATION FOR TREATMENT

Please complete the information below:

Student's Name: _____

Address: _____

City:_____State:_____HomePhone#: _____

Cell Phone #: _____Name of Legal Guardian: _____

LIST THREE (3) EMERGENCY CONTACTS:

Emergency Contact 1: Name: _____Phone: _____

Emergency Contact 2: Name: _____Phone: _____

Emergency Contact 3: Name: _____Phone: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel to administrator treatment to my son/daughter.

Student Name: _____

Every effort will be made to contact the parent/guardian so that specific authorization can be acquired before medical treatment or hospitalization is administered.

Signature of Parent/Guardian: _____

Medical Insurance Provider: _____

Policy # _____

Family Doctor: _____Phone: _____

Student Health Information: _____

Allergies: _____ Medications: _____

Known Medical Issues: _____

Last Tetanus Shot: _____