EMERGENCY INFORMATION/MEDICAL TREATMENT AUTHORIZATION

Student's Name: _____ Grade: _____
Last First Middle

Date of Birth: ____/____/____ Age: _____

Address: _____
Street City/Town State Zip

Student Resides with: _____
Parent/Guardian #1: _____ Email: _____
Home Telephone: _____ Work Telephone: _____
Cell Telephone: _____ Pager: _____

Parent/Guardian #2: _____ Email: _____
Home Telephone: _____ Work Telephone: _____
Cell Telephone: _____ Pager: _____

Alternate Emergency Contact: _____ Email: _____
Home Telephone: _____ Work Telephone: _____
Cell Telephone: _____ Pager: _____

Primary Care Physician: _____ Telephone: _____
Dentist: _____ Telephone: _____

Pre-existing Conditions: _____

All medications taken (including vitamins): _____
ALLERGIES to:
Medication: _____
Food: _____

Insurance Provider: _____
Policy Holder: _____ Student's Policy #: _____

In the case of an emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency facility if necessary.

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I also give permission to exchange information with my child's primary care physician for the purpose of referral and treatment.

SIGNATURE: _____ Date: _____
Parent or Guardian