MEDICAL INFORMATION & EMERGENCY FORM

Student's Name (first, middle, last): _____

Address: _____

Birthdate: _____ **Grade Level:** _____ **Sex:** _____ **M** _____ **F**

Home Phone: _____ **Home E-mail:** _____

Father: _____
Full Name **Including area code: Home Phone** **Cell Phone** **Work Phone**

Mother: _____
Full Name **Including area code: Home Phone** **Cell Phone** **Work Phone**

Emergency Contacts – Local Relative or Friend if Parents cannot be reached:

Name (first, last): _____ Phone (including area code): _____

Name (first, last): _____ Phone (including area code): _____

Student's Primary Physician:

Name (first, last): _____ Phone (including area code): _____

Medical Conditions:

Please list any medical conditions of the student/minor (asthma, diabetes, epilepsy, etc.): _____
_____

List any allergies or allergic reactions to medications of the student/minor: _____
_____

List any medications the student/minor is presently taking: _____
_____

Other pertinent medical information: _____
_____

Date of student/minor's most recent tetanus shot: _____

Medical Insurance Information:

Company: _____

Plan Number: _____ Employee Identification #: _____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the school/parish. A copy will be distributed to the person in charge of each trip or athletic activity in which the student/minor participates. Should the need arise this information will be given to the proper medical authorities.

I, _____ [parent/guardian], understand that in the case of illness or injury to my child, _____[child's name], the school/parish will try to notify me or the person I have listed above as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school/parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

_____ _____
Signature of Parent/Guardian Date

This Authorization for Emergency Medical Treatment is valid for a period of one year.