EMERGENCY CONTACT AND CURRENT MEDICAL INFORMATION

STUDENT INFORMATION				
Name:			Date of Birth: / /	
Home Address:		City:	State:	ZIP:

EMERGENCY CONTACTS				
NAME	RELATIONSHIP	HOME PHONE	MOBILE PHONE	WORK PHONE
		( )	( )	( )
		( )	( )	( )
		( )	( )	( )

PHYSICIAN INFORMATION		
PHYSICIAN'S NAME	ADDRESS	PHONE
		( )

MEDICAL CONDITIONS
1.
2.
3.

Allergies:	Do you wear glasses? Contacts?	Date of last tetanus: / /

ALLERGIES TO MEDICATIONS

MEDICATION	REACTION

CURRENT MEDICATION REGIMEN (please include both prescription and non-prescription medication)

MEDICATION	DOSAGE	FREQUENCY	CONDITION / SPECIAL NOTES

CONTINUED ON BACK

Primary Insurance Company: _____

Phone #s: (_____) _____ - _____ (_____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____

Phone #s: (_____) _____ - _____ (_____) _____ - _____

Billing Address: _____

Policy Holder's Name: _____

Address: _____

Relationship to child/children: _____

ID #: _____ Group/Policy #: _____

Statement of Consent:

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____