EMERGENCY MEDICAL TREATMENT FORM

Student's Name_____ Birth Date_____

Address_____

Parent/Guardian Names_____

Home Phone Number_____ Emergency Phone Number_____

Nearest Relative and Phone Number(s)_____

Past Illnesses_____

Date of Last Tetanus_____

Other Immunizations_____

Allergies_____

Routine Medications_____

Current Health Concerns_____

Other Important Medical History_____

Insurance Company_____
Policy #_____ Group #_____
Subscriber_____

Physician (Name, Phone No., Address)_____
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In the event that the above named student is injured or taken ill and I am not present or immediately available, I authorize any emergency medical care as the attending physician, emergency medical technician, or other qualified health care provider may deem necessary for the health, welfare and safety of the student.

State of _____
County of _____
The foregoing document was acknowledged before this _____ day of _____, 2017 by _____.
My Commission expires:_____ (SEAL)

Notary Public _____