

MEDICAL INFORMATION

Student/Minor

Name (first, middle, last): _____

Address: _____

Emergency Contact

Parent(s) or Guardian: _____

Name (first, middle, last): _____

Phone (including area code): _____

Other contact

Name (first, middle, last): _____

Relationship (friend, relative,
neighbor, etc): _____

Phone (including area code): _____

Student/Minor's Regular Physician

Name (first, middle, last): _____

Phone (including area code): _____

Medical conditions

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

Please list any allergies or allergic reactions to medications of the above student/minor:

Please list any medications the above student/minor is now taking:

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

Other pertinent medical information:

Medical Insurance Information

Company: _____

Identification number of plan: _____

Identification number of covered employee: _____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the school/parish and distributed to the person in charge of each and every trip on which my child participates, or athletic activity. Should the need arise, this information will be given to the proper medical authorities.

I, _____ [name of parent/guardian], understand that in the case of illness of my child, _____ [name], _____ [name of school/parish], will try to notify me or the person I have listed below 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 supervising employee to do as follows:

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

Signature of Parent/Guardian

Printed name of Parent/Guardian

Printed name of Parent/Guardian

Date: _____

Date: _____

This Authorization for Emergency Medical Treatment is valid for a period of one year, from August 20, 2017 through August 20, 2018.