Student Emergency Medical Form

Student Name_____ Date of Birth_____

Address _____ City _____

Home Phone # _____ Parent Cell # _____

Mother's Name _____ Phone # _____ Work # _____

Father's Name _____ Phone # _____ Work # _____

Name of additional Authorized Person to contact if parents are not available:

Name _____Phone # _____

Relationship_____

Doctor's Name _____ Preferred Hospital _____

Please list any information concerning student's medical history, including allergies, present medications taken, any physical impairments and additional medical concerns.

_____

_____

_____

Emergency Medical Authorization

_____ Yes, I authorize consent for emergency medical treatment.

_____ No, I DO NOT authorize emergency medical treatment.

Signature of Parent/ Legal Guardian _____ Date _____

Please complete and sign form. Student will need to bring to the first class session.