

**DOWNRIVER CAREER TECHNICAL CONSORTIUM  
EMERGENCY MEDICAL INFORMATION**

PLEASE FILL THIS FORM OUT COMPLETELY

Student's Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
(Number) (Street) (City) (Apt. #)

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Program Enrolled in: \_\_\_\_\_ Instructor: \_\_\_\_\_

Sending School: \_\_\_\_\_ Receiving School: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event a parent cannot be reached in case of an emergency, please provide us with two additional contacts:

1) \_\_\_\_\_  
(Name) (Relationship) (Phone)

2) \_\_\_\_\_  
(Name) (Relationship) (Phone)

Does your child have any physical/medical difficulties or needs we should be aware of?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hospital Preferred: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_ Membership #: \_\_\_\_\_

I hereby authorize the teacher, administrator or other school personnel to take my child to any doctor or hospital that will care for the child in case they are unable to contact any of the persons listed on this card. Any expense incurred by the emergency will be paid by the parents.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If it is necessary to change any of the emergency medical information, please notify your child's teacher or the school office immediately. This is important for your child's safety and welfare.*