SETON
CATHOLIC SCHOOL

2016-2017
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MEDICAL INFORMATION & EMERGENCY FORM

STUDENT:

Name (first, middle, last): _____
Address: _____
_____

STUDENT'S REGULAR PHYSICIAN:

Name: _____ Phone: (___)_____

MEDICAL CONDITIONS:

Please list any medical conditions of the student (asthma, diabetes, epilepsy, etc.): _____
_____
List any allergies or allergic reactions to medications of the student: _____
_____
List any medications the student is presently taking: _____
_____
Other pertinent medical information: _____
_____

Date of student's most recent tetanus shot: _____

MEDICAL INSURANCE INFORMATION:

Company: _____
Plan Number: _____ Employee Identification #: _____

EMERGENCY CONTACTS:

Parent(s) or Legal Guardian(s):

Mother's name (first, middle, last): _____
Place of employment: _____
Phone (include area code) WORK:_____
HOME:_____
CELL:_____

Father's name (first, middle, last):_____
Place of employment: _____
Phone (include area code) WORK:_____
HOME:_____
CELL:_____

PLEASE COMPLETE BACK OF FORM ALSO

ADDITIONAL EMERGENCY CONTACTS:
(EVERY STUDENT IS REQUIRED TO HAVE TWO)

Name (first, middle, last): _____

Phone **(where they can be reached during school hours)** area code:_____ _____-_____

Relationship: _____

Name (first, middle, last): _____

Phone **(where they can be reached during school hours)** area code:_____ _____-_____

Relationship: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school. A copy will be distributed to the person in charge of each trip in which the student participates. Should the need arise this information will be given to the proper medical authorities.

I, _____ (**parent/guardian**), understand that in the case of illness or injury to my child, _____ (**student name**), the school will try to notify me or the person I have listed above 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 to 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 Date

This Authorization for Emergency Medical Treatment is valid for a period of one year, from August 20, 2015 through August 20, 2016