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, 2016 through August 20, 2017.