

Emergency Contact Form – 2010-2011

Family Name _____

Student Name _____

Date of Birth _____

Student Name _____

Date of Birth _____

Parent Name (or Guardian) _____

Home Phone _____

Cell Phone _____

Work Place _____

Work Phone _____

Parent Name (or Guardian) _____

Home Phone _____

Cell Phone _____

Work Place _____

Work Phone _____

Persons to Contact If Parents Not Available (please complete both names:

1) Name _____

Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

2) Name _____

Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Physician _____ Phone _____ Fax _____

Medical Insurance Plan Name _____

Contract/Group/I.D. Number _____

Medical Condition _____ Allergies _____

Other information regarding your child's health or education that you would like to share

PARENTAL PERMIT (FOR STUDENTS UNDER 18)

I hereby give permission for such diagnostic, therapeutic and operative procedures as may be deemed urgent and necessary by the resident physician or other health care professionals to be performed for my child(ren)

I additionally authorize that a photocopy of this authorization is as valid as the original for purposes of obtaining emergency treatment.

SIGNED _____ Date _____

NAME (PLEASE PRINT) _____ RELATIONSHIP _____