

FALL 2009 MEDICAL INFORMATION AND RELEASE

Student's Name: _____ Date of Birth: _____

Parent's Name: _____

Home Phone: _____ Work: _____ Cell: _____

Parent's Name: _____

Home Phone: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship to the Student: _____

Home Phone: _____ Work: _____ Cell: _____

Medical/Dental Insurance Information:

Medical Insurer: _____ Group/Policy #: _____

Doctor: _____ Phone: _____

Dental Insurer: _____ Group/Policy #: _____

Dentist: _____ Phone: _____

Emergency Treatment Information: Please list any medical conditions, problems, information (including medicines and allergies) that would be necessary for emergency medical personnel to know when administering treatment: _____

Consent for Medical Treatment: As the parent or legal guardian of the above named student, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry. This care may be given under whatever conditions are necessary to preserve the life and limb or well-being of my dependent.

Signature(s) of Parent(s)/Guardian(s):

Date: _____