

EMERGENCY MEDICAL TREATMENT FORM

Student's Name _____ Birth Date _____

Address _____

Parent/Guardian Names _____

Home Phone Number _____ Emergency Phone Number _____

Nearest Relative and Phone Number(s) _____

Past Illnesses _____

Date of Last Tetanus _____

Other Immunizations _____

Allergies _____

Routine Medications _____

Current Health Concerns _____

Other Important Medical History _____

Insurance Company _____

Policy # _____ Group # _____

Subscriber _____

Physician (Name, Phone No., Address) _____

In the event that the above-named student is injured or taken ill, and I am not present or immediately available, I authorize any emergency medical care as the attending physician, emergency medical technician, or other qualified health care provider may deem necessary for the health, welfare, and safety of the student.

State of _____

County of _____

The foregoing document was acknowledged before this _____ day of _____, 2020 by _____.

My Commission expires: _____ **(SEAL)**

Notary Public _____