Emergency Information and Authorization for Medical Treatment

Student name _____ Age _____

Address _____

City, State _____ Zip _____

Phone _____

Insurance company _____ Policy number _____

Insurance company phone _____

Emergency Contacts:

1. Name _____ Relationship _____

   Work phone _____ Home Phone _____

2. Name _____ Relationship _____

   Work phone _____ Home Phone _____

3. Name _____ Relationship _____

   Work phone _____ Home Phone _____

Medical Information: (Check only if condition is present or recurring.)

_____ Diabetes _____ Asthma ____ Heart Condition

_____ Hemophiliac _____ Hearing Aid _____ Wears Glasses

_____ Neuro/Muscular Problem _____ Allergy

_____ Other, please specify _____

If any are checked please explain _____

_____

Is the student on any type of medication? _____ yes _____ no

If yes, what is the dosage? _____

_____

In case of a serious illness, I hereby authorize hospital officials to make whatever arrangements necessary and to contact me immediately. I understand that it remains my responsibility to make any future changes in the information on this medical form as the need arises, by contacting Southeast Louisiana AHEC. Otherwise, this authorization will remain in effect as it appears this date. Neither Southeast Louisiana AHEC nor LSU Health Sciences Center – New Orleans assume responsibility for medical charges. In addition, during your child's participation in this program, they may be photographed for a future publication or display.

Parent/Guardian Signature _____ Date _____