The Marshall School

Medical & Emergency Information

Name_____ DOB _____

Address _____

Father's Name _____ Phone Number _____

Place of Work _____ Email _____

Mother's Name _____ Phone Number _____

Place of Work _____ Email _____

Doctor's Name _____ Phone Number _____

Insurance Company _____ Policy Number _____

Allergies: _____

Medications: _____

Emergency Contact _____ Phone Number _____

Relationship _____

My child has permission to be picked up by the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I give The Marshall School permission to administer and / or seek medical care for my child _____. I further agree that the attending physician or whomever he or she may designate may evaluate and treat all injuries or illnesses for which help is sought. Treatment may proceed without prior notification of the undersigned parent or guardian, although every attempt will be made to notify the parent or guardian in the event of such an injury or illness.

_____ _____

Signature of parent or guardian **Date**