

**2017/2018 Emergency Medical Information**

**Student's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Male / Female (*Please circle one*)

**Parents' Name (Father)** \_\_\_\_\_  
 (Mother) \_\_\_\_\_

**Address** \_\_\_\_\_  
 Full Street Address

**Home Phone #** \_\_\_\_\_

**Allergy / Illness**

Present medical or chronic conditions (asthma, epilepsy, allergies, injuries, etc)- If none exists, write "none".

**Special Circumstances** (speech delay, occupational therapy, etc.) \_\_\_\_\_

**Family Doctor** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Hospital or Medical Facility** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Medical Insurance Company** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Insurance Policy/ Group #** \_\_\_\_\_

**Consent Form for Medical Treatment**

**Parent Release:** In case of an emergency and neither I nor any of the listed names on this emergency form can be reached, I give permission for a member of the S.E.E.D.S. staff to transport my child with them to a licensed physician or emergency room facility. Please accept this as my authorization to provide any necessary medical treatment for my child at such facility.

**Name of Signer (Print)** \_\_\_\_\_

**Type of Identification** \_\_\_\_\_ # \_\_\_\_\_ **Exp. Date** \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

Subscribed and sworn to me before this \_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_.

\_\_\_\_\_  
 Notary Public