

2019/2020 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