

EMERGENCY MEDICAL INFORMATION

First Name _____ MI _____ Last _____ Date of Birth _____ Age _____
Parent/Guardian _____ Telephone _____ (home) _____ (work) _____
Home address _____ City _____ State _____ Zip _____
Emergency Contact _____ Telephone _____
Emergency Contact _____ Telephone _____

General Information: Please indicate any relevant medical or miscellaneous information about your child

Allergies: Food, medicines, insects, plants _____

List any medication to be taken by child _____

List any physical or behavioral conditions that may affect your child _____

List equipment needed such as wheelchair, braces, glasses, contact lens _____

Name of Child's Physician _____ Telephone _____

Name of Child's Dentist _____ Telephone _____

Hospital Preference _____ Telephone _____

PARENT AUTHORIZATION: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 2) the transfer of the student to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

REFUSAL TO CONSENT: I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Art Explorer Post advisor(s) to take the following action:

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____