Medical Information

Student: _____ Parent/Guardian: _____

Address: _____ Address: _____

Home phone: _____ Home phone: _____

Work phone: _____ Work phone: _____

Cell phone: _____ Cell phone _____

Please describe completely any medical condition (past or present) being treated which may occur to be a factor in medical treatment (including allergies, medical reactions, disease of any kind, physical handicaps, heart or lung problems, seizures, convulsions, blackouts, etc.) if currently taking medication, state the medication and prescribing physical and phone number.

_____

_____

I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for their own insurance coverage during this trip or conference.

_____ _____

Insurance Company Policy Number

_____ _____

Parent/Guardian Signature Date

☐ Yes, I give my permission for immediate medical treatment as required by the attending physician. _____ is the person authorized to grant permission for medical treatment for my child.

_____ _____

Parent/Guardian Date

☐ No, I do not give permission for immediate medical treatment until after I have been contacted. Then, _____ is the person authorized to grant permission for treatment of my child.

Parent/Guardian: _____ Date: _____

Please bring these items as soon as possible.