Student Medical Release Form/Permission to Treat

Student Name: _____ Date of Birth: _____

Family Physician: _____ Phone: _____

Address: _____

Insurance Information:

Insurance Company: _____

Policy number: _____

Group Number: _____

Cardholder: _____ Relationship to Cardholder: _____

Insurance Company Phone: _____

Emergency Contact Information:

Parent/Guardian: _____

Home Phone: _____ Work Phone: _____

Secondary Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Please list any current Medical Diagnosis, allergies, prescriptions/dosages, and other relevant medical information:

_____

_____

_____

_____

Parent or Guardian Authorization:
In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

_____

Authorized Parent/Guardian Signature