Emergency Medical Treatment

We cannot seek emergency medical treatment for your child, if necessary, without parental/guardian permission. Please complete the form below so that if your child requires medical treatment while under the supervision of the school, treatment will be authorized.

Family Information

Child's Name: ________________________________ Gender M___ F___

Grade: ____________ Age: ______ Date of Birth: ____________ SSN: ____________________

Parent's Name: ____

Father's SSN: ___________________________ Mother's SSN: ______________________

Home Address: ____

Work Address (es):____

Daytime Phone Number(s): ____

Another Contact Person: ____

Relationship: ___________________________ Daytime Phone#:___________________

Insurance Company: ____

Policy #:_______________________________ Group #:________________________

Allergies: ____

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Medications (including frequency and dosage):____

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Parental Consent

I hereby give permission for my child ______________________________ to receive emergency medical treatment when judged necessary by representatives of Spring Hill Academy.

Signature____________________________________ Date________________

Printed Name________________________________