MEDICAL INFORMATION

Student Name:

Parent/Guardian:

Address:

City, State, Zip:

Student Cell Phone:

Parent Cell Phone:

Alternate Emergency Contact Name and Cell:

Doctors Name:

Doctors Phone:

Please describe completely any medical condition (past or present) being treated which may recur or be a factor in medical treatment (include allergies, medicine reactions, disease of anykind, physical handicaps, heart/lung problems, seizures, convulsions, blackouts, etc.). If currently taking medication, state medications and prescribing physician and phone number:

We certify that the information described above is accurate and complete to the best of our knowledge. We understand that each individual is responsible for their own insurance coverageduring this meeting/ conference.

Name of Insurance Company:

Policy Number:

Instructions: Parent/Guardian – Please check and sign **ONE** of the statements below:

	I **give** permission for immediate medial treatment (as required) by the attending physician. _____(sponsor) is the person authorized to grant permission for medical treatment for my son/daughter.
	I **DO NOT give** permission for medical treatment until I have been contacted. If, after I have been contacted, I consent to medical treatment _____ (sponsor) is the person authorized to grant permission for medical treatment for my son/daughter.

Parent/Guardian Signature:

Date: