Emergency contact information, authorization for medical treatment, and medical/special needs information

Student's Name _____ **Class** _____

PART ONE: Emergency Contact Information

Parent/Guardian Name(s) _____

Street Address _____

City, State, Zip Code _____

Phone number(s) _____

If a parent/guardian is not available, please contact:

Name _____ Relationship to Child _____

Phone number(s) _____

Name _____ Relationship to Child _____

Phone number(s) _____

PART TWO: Authorization for Medical Treatment

I (We) _____
(Parent(s)/Guardian(s) Names)

Do hereby state that I am (we are) the parent(s)/guardian(s) having legal custody of a minor child born on _____
(Child's date of birth)

If I/we cannot be reached I/we authorize Arin Rusch or another accompanying adult who works at MS 447, 345 Dean Street, Brooklyn, NY, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

This authorization will expire on May 9, 2014.

Signed _____ Date _____

PART THREE: Medical and Special Needs Information

Child's allergies, if any (medication, insects, food, etc.) _____

Usual treatment _____

Existing medical conditions or problems _____

Medications your child is taking (list schedule on reverse) _____

Child's doctor _____ Phone number _____

_____ _____ _____
(Insurance Company) (Group #) (ID #)

Date of last tetanus shot _____

Other special needs/anything else we should know? *(Feel free to use the back)*_____

_____