Please be sure to include with this form:

☐copy BOTH sides of insurance card
☐ signed & sealed before a Notary Public

EMERGENCY MEDICAL TREATMENT FORM 2023

Student Name (first, middle, last) _____

Street Address _____

City/State/Zip _____

PARENT/LEGAL GUARDIAN INFORMATION:

Mother/Guardian _____ Father/Guardian _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

IF PARENTS/GUARDIANS CANNOT BE CONTACTED, PLEASE CONTACT:

Name _____ Relationship _____

Street Address _____ City/State/Zip _____

Cell Phone _____ Home Phone _____

INSURANCE INFORMATION (Blue Cross, PPO, HMO, Other) ☐ **copy BOTH sides of Insurance card attached**

Policy Holder's Name _____ Insurance Company _____

Group No. _____ Service Code _____

Contract # _____ Policy Holder's Employer _____

MEDICAL INFORMATION

Date of last Tetanus shot: _____ Special Dietary Needs? _____

Primary Care Physician _____ Physican Phone _____

List allergies (Food / Medication) _____

Medical condition or medical history that should be known to medical staff: _____

☐ Diabetic? How often is blood sugar monitored? _____ list insulin _____

IMPORTANT: this section must be completed in the presence of a Notary Public. Do not sign ahead of time.

Medical Treatment/Disciplinary Release: If the parents and authorized physician named cannot be reached at the time of an emergency and if immediate observation or treatment is urgent in the perception of school authorities, I authorize that my son/daughter be taken to the hospital for emergency medical treatment.

Parent Signature _____

Date _____

Notary Public Signature _____

Date _____

Notary Public: place seal in space above

MEDICATION RELEASE

I, _____, hereby give permission for New York trip chaperones to administer the following medications if necessary: (check if applicable)

____ Tylenol ____ Benadril ____ Aspirin
____ Antacid/Pepto Bismol ____ Ibuprofen/Motrin ____ Cold/Sinus Medication

Please list any medication that your child will need to take while on this trip. All medications must be sent in the original containers and properly labeled with the students name, medication name, dosage amount, and administration time. Remember to list any non-prescription items such as vitamins or herbal supplements.

Medication Name	Dosage	Administration Time

☐ Yes, my child is allowed to self-administer his/her medications.
☐ No, my child is not allowed to self-administer his/her medications.

Student received their last tetanus shot _____ _____
Month Year

MEDICAL TREATMENT / DISIPLINARY RELEASE

If the parents and authorized physician named cannot be reached at the time of an emergency and if immediate observation or treatment is urgent in the perception of school authorities, I authorize that my son/daughter be taken to the hospital for emergency medical treatment.

_____ / _____
Parent's Signature Date