

# CARD FOR EMERGENCY OR ILLNESS

(Fill in **both sides** in ink)

Student's Name \_\_\_\_\_  
Last First Middle Initial

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Mo. Day Yr. Tel. \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Father's Name \_\_\_\_\_  
Last First

Father's Address \_\_\_\_\_  
Street City State Zip

Father's Place of Employment \_\_\_\_\_ Tel. \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Last First

Mother's Address \_\_\_\_\_  
Street City State Zip

Mother's Place of Employment \_\_\_\_\_ Tel. \_\_\_\_\_

Child lives with \_\_\_\_\_

Health Conditions: \_\_\_\_\_  
\_\_\_\_\_

Choice of Hospital \_\_\_\_\_

Family Physician \_\_\_\_\_ Tel. \_\_\_\_\_

Family Dentist \_\_\_\_\_ Tel. \_\_\_\_\_

If parents cannot be reached in emergency, contact \_\_\_\_\_  
Name

Address Phone

I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child

in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital and both physician and nursing personnel within the hospital as well as any physician where treatment is rendered in the physician's office. I release from medical responsibility and liability the hospital, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary for my minor child.

Signature of Parent or Legal Guardian Date

Witness