

Parental Authorization for Emergency Treatment

Child's Name: _____ Grade: _____
(Last Name) (First Name)

Address: _____ Phone: _____

I (we) the parent(s)/guardian(s) _____ do hereby authorize the examination and emergency treatment of my son/daughter _____ as may be indicated by emergency department physician of the closest medical facility while my child is under the supervision of the Four Seasons School Age Program. I authorize the Four Seasons staff to obtain ambulance transport for my child in case of an emergency.

UNDER NO CIRCUMSTANCES WILL THE STAFF OF FOUR SEASONS TRANSPORT AN INJURED INDIVIDUAL. If a medical emergency occurs, 911 will be called and the ambulance/emergency vehicle will transport the injured individual. The parents/guardian are responsible for payment of the ambulance/emergency use.

Name of medical insurance company: _____

Address: _____ Phone Number: _____

Group Policy Number: _____ Date: _____

Signature: _____

Student Health Emergency Data

Grade: _____ Date of Birth: _____ Date: _____

Student Name: _____
(Last Name) (First Name) (Middle Initial)

Address: _____

Student Resides With: Mother Father Both Other

Physician's Name: _____ Physician's Phone Number: _____

Physician's Address: _____

MEDICAL HISTORY:

Does your child suffer from any allergies to foods, medications or other? YES NO

If yes, please list: _____

Does your child have any medical conditions? (i.e.) diabetes, asthma, etc.) YES NO

If yes, please list: _____

Please indicate any special needs, concerns regarding your child: _____
