EMERGENCY CONTACT FORM AND MEDICAL RELEASE FOR 2011-2012

Student's Name: ____ Grade: ______ Date of Birth: _________________ Gender: M or F

Parent/Legal Guardian: __________________________________

Address:____

Home Phone: ____

Cell phone: ____

Place of Work:____

Work Phone:____

Parent/Legal Guardian:__________________________________

Address:____

Home Phone:____

Cell Phone:____

Place of Work:____

Work Phone:____

Person(s) to contact if parents cannot be reached at the phone numbers listed above (list someone locally)
(**THIS SECTION MUST BE COMPLETED**)

First Call: Name: ______________________________________ Phone: __________________________

Second Call: Name: ______________________________________ Phone: __________________________

Third Call: Name: ______________________________________ Phone: __________________________

Does your child have any life threatening health conditions? (i.e. **Bee Sting Allergy, Asthma, etc.**) [ ] yes [ ] no
If yes, please describe treatment:

Does your child have any other unusual health conditions or physical disabilities? [ ] yes [ ] no
If yes, please describe treatment:

Family Physician: ____Office Phone: _______________________________________

In the event of a medical emergency, I authorize Hawthorne Valley School to contact the appropriate person listed above and/or to obtain the necessary emergency treatment for my child.

In the event of a serious emergency, the student will be transported to the nearest health care facility and the parent/guardian will be notified.

____ ______________________________

Signature of Parent /Legal Guardian **Date**

<u>HEALTH INSURANCE INFORMATION</u>

Company Name and Address: (if none, please indicate) ____

Name of Insured: __________________________________ Policy Number: ____

Other Insurance Coverage: ____