



## 2012-13 Emergency Contact and Medical Information

Child's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Emergency Contact Information

If your child is injured or becomes ill at school, please list the names and phone numbers of three people who can be contacted to pick him/her up from school and/or give permission to administer medicine. List the names and phone numbers in the order you want them called.

Name	Phone #
1. _____	_____
2. _____	_____
3. _____	_____

### Medical Information

Hospital/Clinic Preference: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

### Authorization for Treatment

I hereby authorize any physician, surgeon, or dentist on the medical staff of Saint Francis Hospital at Broken Arrow or nearest medical facility to administer any emergency treatment, procedure or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child. If this is not satisfactory, please list specific emergency instructions in the event that you cannot be reached.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

### Special Health Concerns

Does your child wear glasses? Yes No

Does your child have any serious allergies? Yes No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If your child has food allergies, you must complete and submit a "Food Allergy Action Plan" each year.

