

MEDICAL EMERGENCY CONSENT FORM

This information is requested as a precaution in the event medical treatment is required and the Escondido Charter High School staff is unable to contact a responsible party.

Student Name: _____
Last
First
Middle

Sex: _____ Birthdate: _____ Age: _____

Parent or Guardian Names: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ TCP or ILP? _____

If not available in an emergency, notify:

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

This student has the following allergies:

This student has the following medical or health problem(s):

This student is on the following medications: _____

Date of last Tetanus shot: _____

PHYSICIAN INFORMATION

The name, address, medical specialty and phone number of student's family physician and of any other physician or dentist who should be consulted in the event of emergency or medical problems involving this child:

Name of Primary Physician:		Specialist:	
Phone # of Physician:		Specialist Phone #:	
Physician's Emergency Exchange:			
Address of Physician:			

The name, telephone # and address of student's dentist (and orthodontist if applicable):

Dentist: _____
 Orthodontist: _____

INSURANCE INFORMATION

	Primary Insurance Information	Secondary Insurance Information
Name of Insurance Carrier:		
Phone # of Insurance Carrier:		
Address of Insurance Carrier:		
Name of Policy Holder:		
Policy Number:		

I understand that, in the event my child requires medical or dental treatment while engaged in a school activity, reasonable efforts will be made to contact me. However, if I cannot be reached, I hereby consent and give permission to the school sponsor or any adult counselor acting on behalf of the Escondido Charter Schools with respect to the activity, as agent for me, to consent to any X-ray examination; injections; anesthesia; medical, dental or surgical diagnosis and treatment; and hospital care and treatment advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either as an outpatient or in any hospital. To the best of my knowledge, I have listed above all of my child's medical allergies, medications being taken, medical problems and other pertinent information.

Signature: _____ Date: _____
(Parent or Guardian)

Print Full Name: _____ Date: _____