



EMERGENCY CONTACT/ PARENTAL CONSENT FORM

CHILD'S NAME: _____

PRIORITY PHONE NUMBER	
ADDRESS	
BIRTHDATE	
PARENT 1 NAME	
PARENT 1 ADDRESS	
PARENT 1 CELL PHONE	
PARENT 1 WORK PHONE	
PARENT 1 EMAIL	
PARENT 2 NAME	
PARENT 2 ADDRESS	
PARENT 2 CELL PHONE	
PARENT 2 WORK PHONE	
PARENT 2 EMAIL	
EMERGENCY CONTACT #1	
NAME, RELATION	
PHONE	
EMERGENCY CONTACT #2	
NAME, RELATION	
PHONE	
EMERGENCY CONTACT #3	
NAME, RELATION	
PHONE	
ADDITIONAL PERSON(S) TO WHOM THE CHILD MAY BE RELEASED	

Child's Name: _____

MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY: _____

GROUP NUMBER(S): _____

ID NUMBER: _____

STUDENT'S MAJOR MEDICAL HISTORY

(Please feel free to attach additional pages or documents, e.g., allergy plans, 504s, IEPs, as needed.)

CHILD'S PHYSICIAN'S Practice, Name, Address, Phone Number	
HOSPITAL PREFERENCE	
ALLERGIES (Y / N) If yes, please list allergies and include an allergy plan from your child's doctor, if applicable.	
SEIZURE DISORDER (Y / N)	
DIABETES (Y / N)	
OTHER major medical condition (Y / N) If yes, please explain.	

MEDICAL EMERGENCY CARE CONSENT

I/we authorize SPNDS staff to administer first aid to our child in the event of accident or illness. If, in their judgment, there is a medical emergency requiring more than minor first aid, I/we authorize SPNDS staff to accompany our child to the most convenient hospital or medical center in a police or other vehicle and to obtain medical care.

I/we understand that a reasonable effort will be made to locate me/us but that steps to obtain emergency care for our child will not be delayed. I/we understand that I/we may be required to provide further consent to Crozer-Chester Medical Center and/or other emergency institution.

Parent(s) Signature: _____ **Date:** _____

_____ **Date:** _____