



## **STUDENT EMERGENCY TREATMENT FORM**

Authorization: I hereby give permission to the medical personnel selected by the JCC to secure and administer treatment, including x-rays, routine tests and hospitalization for the child named below:

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent 1 Name \_\_\_\_\_ Phone \_\_\_\_\_

Parent 2 Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Parent Signature \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_ Phone \_\_\_\_\_

## **HEALTH HISTORY**

### **Check and include approximate dates**

- ☐ Frequent Ear Infections
- ☐ Heart Defect
- ☐ Convulsions
- ☐ Diabetes
- ☐ Bleeding/Clotting
- ☐ Disorders
- ☐ Hypertension
- ☐ Psychiatric Treatment
- ☐ Mononucleosis

### **Allergies**

- ☐ Hay Fever
- ☐ Ivy Poisoning etc.
- ☐ Insect Stings
- ☐ Penicillin
- ☐ Other Drugs
- ☐ Asthma
- ☐ Products
- ☐ Peanuts
- ☐ Other

### **Diseases**

- ☐ Chicken Pox
- ☐ Measles
- ☐ German measles

Is your child currently receiving special help with emotional and/or behavioral issues at home or school? (i.e. psychiatrist, social worker, counselor, etc.) ☐ Yes ☐ No

Do you carry family medical/hospital insurance? ☐ Yes ☐ No

If so, please complete information below:

Carrier \_\_\_\_\_ Policy or Group # \_\_\_\_\_