



**EMERGENCY CONTACT INFORMATION**

**Parent/Guardian Name:** \_\_\_\_\_ Relationship \_\_\_\_\_  
Address (if different than one given on reverse): Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_  
Home Ph ( ) \_\_\_\_\_ Home Fax ( ) \_\_\_\_\_ Work Ph ( ) \_\_\_\_\_  
Work Fax ( ) \_\_\_\_\_ e-mail \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**Parent/Guardian location during school session if different than above:**

Dates at this address: \_\_\_\_\_ to \_\_\_\_\_ Name \_\_\_\_\_  
Relationship: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Country \_\_\_\_\_ Ph ( ) \_\_\_\_\_ or ( ) \_\_\_\_\_  
Fax ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ e-mail: \_\_\_\_\_

**Relative to call if you cannot be reached: Name** \_\_\_\_\_

Relationship: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_ Home Ph ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_  
Work Ph ( ) \_\_\_\_\_ Work Fax ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**Student's Physician Name:** \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Country \_\_\_\_\_ Office Ph ( ) \_\_\_\_\_ After hrs ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Medical insurance is not required, but highly recommended. You are responsible for medical costs not covered by insurance. **Name of Insurance Co.** \_\_\_\_\_ **Card or policy#** \_\_\_\_\_

Person responsible for medical expenses: \_\_\_\_\_

**ENCLOSE PHOTOCOPY (front & back) OF STUDENT'S MEDICAL INSURANCE CARD.**

*You may write instructions regarding coverage on the photocopy.*

**AUTHORIZATION FOR EMERGENCY CARE FOR STUDENTS UNDER 18:**

I understand every effort will be made to contact the minor students parent or legal guardian in case of an emergency. However, in the event I cannot be reached: I, \_\_\_\_\_ give

*(Print parent / legal guardian name)*

permission to the health care provider designated by the Meadowmount Administration, to provide treatment deemed necessary to: \_\_\_\_\_

*(Print child's name)*

**Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Witness Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_  
*(Print name)*

**VERIFICATION OF INFORMATION**

I certify that information concerning my (or my child's) health history, including physical/psychological impairments, allergies and current medication are accurate as stated on this form. I will inform the school nurse/staff with updated information if changes occur after sending in this form. I understand that withholding or giving inaccurate medical information necessary to my child's well being may result in immediate dismissal without refund. **All information is kept confidential in the nurse's office and is given to counseling/teaching staff on a need to know basis ONLY.**

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent /Guardian Signature: (if student is under 18)** \_\_\_\_\_ **Date:** \_\_\_\_\_