deToledo High School

EMERGENCY MEDICAL FORM – Summer 2016

Print, sign, and return by mail or in person to the school office at the address below.
Students will not be able to participate unless this form has been signed and submitted.

STUDENT NAME:____
{PLEASE PRINT} **LAST NAME** **FIRST NAME** **M.I.**

In case of an emergency, please list below at least two contacts:

CONTACT ONE:____ ___________________
{PLEASE PRINT} **LAST NAME** **FIRST NAME** **RELATIONSHIP**

HOME #:___________________ **WORK #:**___________________ **CELL #:**___________________

CONTACT TWO:____ ___________________
{PLEASE PRINT} **LAST NAME** **FIRST NAME** **RELATIONSHIP**

HOME #:___________________ **WORK #:**___________________ **CELL #:**___________________

Is there any pertinent medical information (medication, allergies, etc.) that we should know about your student?

____

Insurance Information: Name of insurance company:____

ID #____________________________________ Group #____________________________________

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

No nurse is on the premises. In the event of a serious medical emergency, we will make every effort to contact you. However, if we are unable to reach you, we will need your consent to authorize a medical examination or the treatment of your child by any licensed physician. Since this authorization is so important, we require your signature below before your student can participate in any Summer 2016 course or activity.

I, the undersigned parent/guardian of the student listed above, a minor, do hereby authorize an administrator or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treat or hospital care which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

The authorization shall remain effective for Summer 2016.

MEDICAL PERMISSION

Please indicate if any dTHS faculty/staff member can distribute any of the following over-the-counter medications.

Please check one for each medication.

Acetaminophen (generic Tylenol) {*check one*}	❑ No	❑ 500 mg (one tablet only)	❑ 1000 mg (two tablets)
Ibuprofen (generic Advil) {*check one*}	❑ No	❑ 200 mg (one tablet only)	❑ 400 mg (two tablets)
Benadryl {*check one*}	❑ No	❑ 25 mg (one tablet)	

____ ___________________
PARENT/GUARDIAN SIGNATURE **DATE**

____
PARENT/GUARDIAN NAME {PLEASE PRINT}

Sign and return by Friday, June 3, 2016