

**EMERGENCY MEDICAL FORM – Summer 2018**

Print, sign, and return by uploading to the Summer Registration Site.  
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 2018 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 2018.

**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} | <input type="checkbox"/> No | <input type="checkbox"/> 500 mg (one tablet only) | <input type="checkbox"/> 1000 mg (two tablets) |
| Ibuprofen (generic Advil) {check one}       | <input type="checkbox"/> No | <input type="checkbox"/> 200 mg (one tablet only) | <input type="checkbox"/> 400 mg (two tablets)  |
| Benadryl {check one}                        | <input type="checkbox"/> No | <input type="checkbox"/> 25 mg (one tablet)       |  |

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

**PARENT/GUARDIAN NAME {PLEASE PRINT}**

Sign and upload by Thursday, June 7, 2018