



EMERGENCY INFORMATION/ MEDICAL RELEASE FORM FOR A MINOR

THIS FORM SHOULD BE COMPLETED AND RETURNED TO MRS. JONES

Minor's Name: _____ Date of birth: _____
Last First MM/DD/YY

Parent/Guardian's Name: _____

Home Address: _____

City: _____ State: _____ Home Phone: _____ Cell _____
(Area code) Number (Area code) Number

Employer: _____ Work Phone: _____
(Area code) Number(s)

Insurance Provider: _____

Address: _____
Street Address City State Zip Code

Policy No _____

Notify in Emergency (if other than parent or guardian) _____

Relationship: _____ Phone Number: _____
(Area code) Number

Address: _____
Street Address City State Zip Code

Family Physician: _____ Phone Number: _____
(Area code) Number

Current overall health: _____

Allergies: _____ Last Tetanus: _____
MM/DD/YY

Medical Challenges: _____

Medicines: If your child will require any medication while on this trip, even over the counter medication, please complete an Authorization for the Administration of Medication form for EACH medication.

AUTHORIZATION FOR TREATMENT OF MINOR

I, the undersigned, parent or legal guardian of _____, a minor, do hereby consent to authorized medical personnel to perform routine tests and treatment for the health of my child. In the event that I cannot be reached in an Emergency, I hereby give permission for an authorized physician to hospitalize, secure proper treatments, and to order injection, anesthesia, or surgery for my child as named above.

In addition, in the event of any emergency during the Villa Academy School trip to Washington D.C. April 9th- April 14th 2009, the undersigned hereby grants authority to be exercised at the discretion of the group leaders or designated chaperone to dispense over-the-counter medication as necessary.

(Date)

(Parent/Guardian Signature)

RETURN THIS FORM TO SCHOOL NO LATER THAN MARCH 30, 2009