



THEORY OF ARTS & SCIENCES

# RELEASE FOR EMERGENCY CARE

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child \_\_\_\_\_ in the event of an emergency at which tie I cannot be reached. I give consent to transport by ambulance if situation warrants it and agree to pay for such treatment.

## Has the student had:

SURGERY: Y <input type="checkbox"/> N <input type="checkbox"/>	SERIOUS ILLNESS / ACCIDENTS: Y <input type="checkbox"/> N <input type="checkbox"/>	BURNS: Y <input type="checkbox"/> N <input type="checkbox"/>	ALLERGIES: Y <input type="checkbox"/> N <input type="checkbox"/>	CONVULSIONS: Y <input type="checkbox"/> N <input type="checkbox"/>	DATE OF LAST DPT/TETANUS: / /
PREVIOUS HEALTH EXPERIENCES (PLEASE PROVIDE DATES):					

## Physician Information:

STUDENT'S PHYSICIAN NAME:		TELEPHONE:	
ADDRESS:			
CITY:	STATE:	ZIP CODE:	

## Dentist Information:

STUDENT'S DENTIST NAME:		TELEPHONE:	
ADDRESS:			
CITY:	STATE:	ZIP CODE:	

## Health Insurance Information:

INSURANCE COMPANY:	POLICY NUMBER:	GROUP NO.:
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## SIGNATURE

I give permission to consult the student's physician resource listed above in case of emergency if I/we cannot be reached.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_