Beech High School

Buccaneer Brigade

Emergency Treatment Form

To All Parents/Guardians:

Many hospitals and doctors will not treat a child without the parent/guardian consent (unless a matter of life or death) It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Student Name: _____

Gender: _____M _____F Date of Birth: _____/_____/_____Grade Fall of 2017: _____

Father's Name: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Mother's Name: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Secondary Contact: _____ Relationship: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Insurance Co. Name: _____ Phone #: _____

Policy #: _____ Group #: _____

Primary Care Physician: _____ Phone #: _____

Allergies: _____

Medications: _____

Emergency Medical Conditions: _____

CONSENT STATEMENT: Authorizing Treatment

I hereby give my consent for (Student's Name) _____ to be treated in the event of an emergency, injury or illness.

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____ Date:___/___/___