



Community High School

of arts and academics

EMERGENCY TREATMENT FORM COMMUNITY HIGH SCHOOL

Name of Student: _____
 Address: _____
 Parent: _____ Home Phone: _____
 Work Phone: _____ Cell Phone: _____
 Parent: _____ Home Phone: _____
 Work Phone: _____ Cell Phone: _____

EMERGENCY TREATMENT AUTHORIZATION (Minimum of two contacts required)

Names of people to contact in case of accident or illness ***if neither parent can be reached***:

Name: _____ Phone: _____
 Address: _____
 Name: _____ Phone: _____
 Address: _____
 Name of student's physician: _____ Phone: _____
 Health insurance company: _____
 Policy no. _____

A. In the event a parent or guardian cannot be reached, I/we give permission for Community High School to authorize emergency treatment for my/our child.

 Signature of custodial parent Date

B. Please list allergies, medication or eyeglass requirements, or conditions of which the school should be aware:

C. The following are the only non-prescription drugs we have available. Please mark those you authorize:

____ Benedryl ____ Ibuprofen/Acetaminophen ____ antacid tablets
 ____ throat/cough drops

D. Persons NOT authorized to pick up your child:
