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 dugs 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:

____

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