Patricia Henley Foundation
Student Emergency Contact and Medical Information

Child's Name | Date of Birth | M F Sex

Parent's/Guardian's Name | Parent's/Guardian's Name

( ) Home Phone | ( ) Work Phone | ( ) Home Phone | ( ) Work Phone

Cell phone | Cell phone

Address | Address

City, ST ZIP Code | City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact | Secondary Emergency Contact

( ) Home Phone | ( ) Work Phone | ( ) Home Phone | ( ) Work Phone

Address | Address

City, ST ZIP Code | City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name | Phone Number

Insurance Company | Policy Number

Allergies (Bee Stings that require Medication, foods, drugs, other)

Respiratory Problems / Asthma (Medication needed if so, self administered or adult assisted only)

Is the child presently taking any medications? (If so, please list)

Other Special Health Considerations

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies **only** in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature | Date