Student Emergency Information/Medical Treatment Authorization

Student Information

Name: _____ Grade: _____ DOB:_____

Home Address: _____ Home Phone: _____

City/State/Zip: _____

Primary Care Physician: _____ Phone: _____

Physician Address: _____

Dentist: _____ Phone: _____

Dentist Address: _____

Parent/Guardian Information

Parent/Guardian (first contact): _____

Employer & Address: _____

Work Phone: _____ Cell Phone: _____

Parent/Guardian (second contact): _____

Employer & Address: _____

Work Phone: _____ Cell Phone: _____

Other Emergency Contacts

Please list two contacts which will be called **only** in case of an emergency and you cannot be reached

Name: _____ Relationship: _____

Daytime Phone: _____Cell Phone: _____

Name: _____ Relationship: _____

Daytime Phone: _____Cell Phone: _____

Student Allergies: _____

Current Medications: _____

I give permission to Grace Academy to seek emergency medical treatment for my above named child (when under school supervision) any time during the school year. I also authorize Grace to contact my child's physician and request any information needed to provide accurate medical data required by the State of Maryland.

Parent/Guardian Name: (Please Print) _____

Parent/Guardian Signature: _____ Date: _____

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