Delta Safety Village **Emergency Medical Form**

Student Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Parent Names: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Preferred Hospital: _____ Phone: _____

Preferred Doctor: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Allergies: _____

Insurance Provider: _____

Policy # _____ Group # _____

Insured Name: _____

Place of Employment: _____

If after reasonable effort has been made to contact the responsible parties listed above, I give permission to the Safety Village staff for treatment of my child _____. I understand that no major medical procedure will be performed without my consent.

Parent/Legal Guardian Signature: _____

Date: _____