

Delta Safety Village Emergency Medical Form

Student Name: _____

Address: _____

Parent Name(s): _____

Cell Phone: _____ Home Phone: _____

EMAIL: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Preferred Hospital: _____ Phone: _____

Preferred Doctor: _____ 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: _____