EMERGENCY CONTACT FORM AND MEDICAL RELEASE FOR 2016-2017

Student's Name: _____ Grade: _____ Date of Birth: _____ Gender: M or F

Parent/Legal Guardian: _____ Parent/Legal Guardian:_____

Address:_____ Address:_____

Home Phone: _____ Home Phone:_____

Cell phone: _____ Cell Phone:_____

Place of Work:_____ Place of Work:_____

Work Phone:_____ Work Phone:_____

Email Address: _____ Email Address: _____

Person(s) to contact if parents cannot be reached at the phone numbers listed above (list someone locally)
(**THIS SECTION MUST BE COMPLETED**)

First Call: Name: _____ Phone: _____

Second Call: Name: _____ Phone: _____

Third Call: Name: _____ Phone: _____

Does your child have any life threatening health conditions? (i.e. **Bee Sting Allergy, Asthma, etc.**) ☐ yes ☐ no
If yes, please describe treatment:

Does your child have any other unusual health conditions or physical disabilities? ☐ yes ☐ no
If yes, please describe treatment:

Family Physician: _____Office Phone: _____

In the event of a medical emergency, I authorize Hawthorne Valley Waldorf School to contact the appropriate person listed above and/or to obtain the necessary emergency treatment for my child.

In the event of a serious emergency, the student will be transported to the nearest health care facility and the parent/guardian will be notified.

_____ _____

Signature of Parent /Legal Guardian **Date**

HEALTH INSURANCE INFORMATION

Company Name and Address: (if none, please indicate) _____

Name of Insured: _____ Policy Number: _____

Other Insurance Coverage: _____