2016-17 Boarding or Exchange Student Emergency Contact Form and Medical Release

Form to be completed by the parents or legal guardians of a boarding or exchange student.
Please print clearly and complete entire form.

Student Information

Student's Name (first name, last name): _____Grade (in 2015-2016): _____

Date of Birth (month/day/year):_____ Gender (circle one): male / female

Parents/Legal Guardians Information

First Parent Name (first name, last name): _____

Street Address: _____

_____

City: _____ State / Province / Region: _____

Postal / Zip Code:_____ Country: _____

First Parent Home Phone:_____ First Parent Cell Phone: _____

First Parent Place of Work: _____ First Parent Work Phone: _____

First Parent Email:_____

Second Parent Name (first name, last name): _____

Street Address: _____

_____

City: _____ State / Province / Region: _____

Postal / Zip Code:_____ Country: _____

Second Parent Home Phone:_____ Second Parent Cell Phone: _____

Second Parent Place of Work: _____ Second Parent Work Phone: _____

Second Parent Email:_____

Additional Emergency Contacts

In the event of an emergency, if it is necessary to contact the boarding student's parents, we will contact the parents using the provided information. However, if we are unable to reach the parents directly, we will contact the following two people, who must know how to contact the boarding student's parents. List their contact information.

Person One Name (first name, last name): _____ Phone Number: _____

Person One's Relationship to parents:_____

Person Two Name (first name, last name): _____ Phone Number: _____

Person Two's Relationship to parents:_____

Student Medical Information

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:

Name of Family Physician: _____ Physician Office Phone: _____

Health Insurance Information

Health Insurance Company's Name and Address:

Policy Number: _____

Name of Insured: _____

Other Insurance Coverage/Information:

Signature & Authorization

Your signature serves as proof of consent for appropriate Hawthorne Valley Association personnel to obtain and/or for your child/ward to receive emergency medical care: In the event of a medical emergency, I authorize Hawthorne Valley School representatives and/or the host family to contact the appropriate person(s) listed above and/or to obtain the necessary emergency treatment and/or routine medical care, medications, and vaccinations for my child/ward.

Signature of Parent/Legal Guardian: _____

Date: _____