

### EMERGENCY TREATMENT FORM

One Form per Student – Please Print Clearly

Student's Full Legal Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Medical Plan \_\_\_\_\_ Policy # \_\_\_\_\_ Med Record # \_\_\_\_\_

Physician's Name \_\_\_\_\_ Clinic Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Significant History (allergies, asthma, diabetes, recommendations, etc.) \_\_\_\_\_

Father's Name \_\_\_\_\_ Workplace \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Mother's Name \_\_\_\_\_ Workplace \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

#### IF PARENTS CANNOT BE REACHED, CALL:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

If I am unable to be contacted, Doris Todd Memorial Christian School staff has my permission for \_\_\_\_\_  
to receive emergency care at a hospital or emergency center. Student's Name

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

#### PERSONS AUTHORIZED TO PICK-UP STUDENT(S) FROM SCHOOL

NAME	ADDRESS	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I/We agree to inform DTMCS if we decide to add or delete anyone from this list.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_