NAME OF THE AGENCY, NAME OF AFTER-SCHOOL PROGRAM, SCHOOL

EMERGENCY MEDICAL CARE (To be completed by the parent or guardian)

Student's Name: _____ **Date of Birth:** _____

1. **If my child requires emergency medical care and I cannot be reached, I give my consent to the above after-school program to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.**

2. **This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.**

3. **Following emergency medical care, my child may be released to the following people:**

Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____
Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____
Name:	_____	Relationship to Child:	_____
Address:	_____	Employer:	_____
Home Phone:	_____	Work Phone:	_____

4. **Health/Insurance Information:**

Student's Doctor:	_____	Insurance Company:	_____
Phone:	_____	Policy Holder's ID:	_____
Allergies:	_____	Religious Preference: (optional)	_____
Last Tetanus:	_____	Medication(s) being taken:	_____
Address (student's doctor):	_____		

Additional Comments: _____

5. **I understand that this consent will be in effect as of the date of my signing this form and will continue as long as my child is enrolled in this after-school program.**

_____

Parent/Guardian Signature Date