Emergency Medical Form STUDENT

An EMF is required for each participant in MUMC trips. ***Type or print in ink completing BOTH sides.***

STUDENT INFORMATION

Name:____ Date of Birth:____________________

Address:_________________________________ City:_________________ State:____ Zip Code:_______

School Name:_________________ Grade:______ Email:______________________________________

Home Phone:____________________ Cell phone:_____________________ May we TEXT? Y N

PARENT/LEGAL GUARDIAN INFORMATION

Name:_______________________ Relationship to student:____________ Email:____________________

Name:_______________________ Relationship to student:____________ Email:____________________

Address:_________________________________ City:_________________ State:____ Zip Code:_______

Daytime phone(s):____________________________ Evening phone(s):____________________________

Cell phone(s):____ May we TEXT? Y N

Emergency Contact Person (in case parent or legal guardian cannot be reached)

Name:_______________________ Relationship to student: ____________Phone(s):_________________

Emergency Medical Information

Physical conditions such as disabilities, recurring illness, allergies (ie: dairy, nuts, seafood, insects, animals):

____

____

List all medications currently being taken:____

____

Student permitted to take over-the-counter pain reliever? Y N
Student permitted to take over-the-counter cold/flu medication? Y N
Student subject to motion sickness? Y N
Permitted to take over-the-counter motion sickness medication? Y N
Date of last Tetanus Shot: ______________________________

Participants will be allowed to possess and take over-the-counter and prescription medications on their own if permission is granted in writing by the parent(s) or guardian(s). Both over-the-counter and prescription medications must be in their original containers and listed above. My child understands that any medications are his/her own and are not to be shared with any other persons.

____
Parent/legal guardian's signature Date

Emergency Medical Authorization Information

Insurance Company:____

Policy Subscriber's Name:____________________________________

Policy Number:____________________ Group Number:____________________

____
Name of Family Physician Phone

____
Name of Medical Specialist Phone

____
Name of Dentist Phone

____
Preferred Hospital Phone

Emergency Medical Authorization (Part I or Part II Must Be Completed)

Part I (To Grant Consent)

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-mentioned doctor/medical specialist/dentist or, in the event the designated practitioner is not available, by any other licensed physician or dentist; and (2) the transfer of the child to the preferred hospital or, any hospital reasonably accessible.

I understand that the consent and authorization herein granted do not include major surgical procedures unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

____
Parent or legal guardian's signature Date

Facts concerning student's medical history and physical impairment to which a physician should be alerted:

____

____

Part II (Refusal to Consent)

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I do not give consent for emergency medical treatment of my child. In the event of illness or injury, I do not give the attending physician permission to administer treatment until the parent, guardian or designated individual is contacted.

____
Parent or legal guardian's signature Date