

MEDICAL TREATMENT FORM

**EMERGENCY TREATMENT
RELEASE**

I hereby authorize any licensed physician, EMT or other qualified hospital personnel to render medical treatment to my daughter _____ which, in their judgment, is necessary in the event of illness or injury. I understand that, in all such cases, I will be notified as quickly as possible.

(Signature of Parent or Guardian) (Date)

STUDENT INFORMATION

Student's First Name Middle Name Family Name Preferred Name or Nickname

Home Address City Province/State Country Postal Code

Male _____
 Female Age Date of Birth (Mo/Day/Year)

Provincial Health Card Number: _____

Home Phone Number: _____

Father's Work Number: _____

Mother's Work Number: _____

Additional Permanent Emergency Number: _____

Name of person to contact at this latter number: _____

Relationship to Family: _____

Please list any and all allergies, special medical conditions, special medications or health problems with which Rocklyn Academy should be aware:

Please list any and all medications that your daughter takes on a regular basis. Please include amounts taken, number of daily doses and routine administration times:

Are there any dietary concerns or preferences?

Student Name _____

Blood type (if known): _____

Does your daughter wear contact lenses? _____

Name of Family Doctor: _____

Office Phone Number: _____

Emergency Phone Number: _____

Medical Insurance Policy Name and Number: _____

Name of Family Dentist: _____

Office Phone Number: _____

Emergency Phone Number: _____

Dental Insurance Policy Name and Number: _____

I give permission for my daughter, _____, to see Dr. Christine Harrison, D.C.,
(Chiropractor)

Signature of Parent or Guardian