



HAMPSTEAD ACADEMY

Emergency Medical Authorization Parent Form

Student: _____ **Date of Birth:** _____ **Grade:** _____
First Name Middle Last

Address: _____
Number & Street City//Town State Zip Code Home Phone

Parent/Guardian: _____
First Name Last Preferred Phone Alternate Phone

Parent/Guardian: _____
First Name Last Preferred Phone Alternate Phone

Email Contact(s): _____

Emergency Contact Information

In the unlikely event that we are unable to reach a parent/guardian, please give the name(s) of persons to be contacted in emergency situations.

Contact: _____
First Name Last Preferred Phone Alternate Phone

Contact: _____
First Name Last Preferred Phone Alternate Phone

Emergency Medical Information

Health Insurance _____ Policy Number _____

Physician's Name _____ Physician's Phone # _____

Dentist's Name _____ Dentist's Phone _____

Health Conditions _____

Allergies _____

Current Medications _____

Date of last physical exam _____ Date of last tetanus booster _____

Please read, complete, and sign the following: *I understand that in the event of a medical emergency, all reasonable efforts will be made by the School personnel to contact the student's parent or guardian. When such communication shall fail, or when delay would endanger the life of the student, I authorize appropriate personnel of HA to administer and/or secure emergency treatment for the student, including hospitalizations. I also grant permission for medical information relevant to the student's health and safety to be released to relative persons on a need-to-know basis.*

Parent Signature: _____ **Date:** _____