



Mercy Culture Prep

1401 Oakhurst Scenic Drive
Fort Worth, Texas 76111
phone (817) 332-3351

**MEDICAL INFORMATION AND EMERGENCY MEDICAL
TREATMENT AUTHORIZATION FORM**

STUDENT: last _____ first _____ middle _____

ADDRESS: street _____ city _____ state _____ ZIP _____

PRIMARY CARE PHYSICIAN: _____ phone _____

MEDICAL CONDITIONS: please list all known medical conditions for this student _____

List all allergies and/or allergic reactions to medications _____

List all medications student currently takes _____

Any other medical information for this student _____

MEDICAL INSURANCE: company _____ phone _____

group/plan number/ID _____ policy number _____

EMERGENCY CONTACT: parent guardian _____

primary phone _____ secondary phone _____

Other emergency contact _____ relationship _____

primary phone _____ secondary phone _____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of Mercy Culture Prep. A copy will be distributed to the person in charge of each trip, athletic event, and/or other school sponsored activity in which the above listed student participates. Should the need arise this information will be given to the proper medical authorities.

I, _____ (parent/guardian), understand that in the case of illness or injury to my child, listed above, MC Prep will attempt to notify me and/or the other emergency contact listed above. If a medical emergency concerning my child occurs at a time when neither I nor the other contact listed above can be contacted, I grant the school full authority to arrange for transportation by ambulance or otherwise to a proper facility where emergency medical treatment would normally be administered, including, but not limited to a hospital, a doctor's office, or a medical clinic. Also, I grant full authority for the school to sign releases as may be required to obtain any medical or surgical treatment that is needed according to the judgement of the medical authorities at the facility.

This Authorization for Emergency Medical Treatment is valid for a period of one school year, from July 1, _____ through August 31, _____.

Signature (parent/guardian) _____ **Date** _____