

Emergency Student Information Form

Name of Student: _____

Date of Birth: _____

Home Address: _____

Parent's Names: _____ # _____

_____ # _____

Emergency Contacts: _____ # _____

_____ # _____

Allergies: _____ Medication: _____

_____ Medication: _____

_____ Medication: _____

_____ Medication: _____

As the parent or authorized representative, I hereby give consent to *Odyssey* to obtain all emergency medical or dental care prescribed by a duly licensed physical (M.D.) osteopath (D.O) or dentist (D.D.S) for

_____. This care may be given under whatever conditions are
(name of child)

necessary to preserve the life, limb, or well being of the child named above.

Parent Signature

Date: _____

Parent Signature

Date: _____