



## EMERGENCY TREATMENT AUTHORIZATION

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact #1 \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Facts concerning student's medical history including allergies, medications being taken, and physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone number \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone number \_\_\_\_\_

Orthodontist's Name \_\_\_\_\_ Phone number \_\_\_\_\_

### Insurance Information:

\_\_\_\_\_ Medical Insurance-Hospitalization Plan

\_\_\_\_\_ Name of Subscriber

\_\_\_\_\_ Contract No.

\_\_\_\_\_ Group No.

\_\_\_\_\_ Other Info

### Please sign one of the two sections below:

1. If I/my child require(s) emergency medical treatment while under the jurisdiction of The Fine Arts Association, I authorize The Fine Arts Association to contact emergency medical services and to perform treatment as deemed necessary. I also authorize FAA to release the information contained herein.

\_\_\_\_\_  
Signature of Student or Parent/Guardian

\_\_\_\_\_  
Date

2. I do not give The Fine Arts Association the authority to contact emergency medical services or to perform treatment in the event that I/my child become(s) ill or injured.

\_\_\_\_\_  
Signature of Student or Parent/Guardian

\_\_\_\_\_  
Date