

**Emergency Information & Consent**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contacts (Two people other than the parents/guardians stated above must be provided):

1. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_  
Dentist: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_  
Medical Conditions: \_\_\_\_\_  
Special Medications (especially those to be administered at school): \_\_\_\_\_

Side Effects: \_\_\_\_\_  
Other Important Information: \_\_\_\_\_

Medical/Health Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

***Emergency Medical Treatment Authorization:***

The undersigned(s) being the lawful parent(s) and/or guardian(s) of the above child hereby consent to the participation by the child in all activities conducted by Holy Trinity Episcopal Day School and to the participation of the child in all events related to such activities. The undersigned hereby further authorize(s) any of the staff, employees, agents and representatives of Holy Trinity Episcopal Day School to provide for, approve and authorize any health care at any hospital, emergency room, doctor's office or other institution, employ any physicians, dentists, nurses or other person whose services may be needed for such health care, review and if necessary disclose the contents of any medical records, execute any consent form required by medical, dental or other health authorities incident to the provision of medical, surgical, or dental care to the child. Health care shall include, but not be limited to the administration of anesthesia, x-ray, examination, performance of operations, diagnostic and other procedures. The undersigned(s) hereby further authorize(s) emergency transportation by either school personnel or if necessary by ambulance or other emergency vehicle. If there is no medical emergency, the staff will first use reasonable efforts to contact the parent(s) and /or guardian(s) before administering or authorizing any treatment. The undersigned(s) agree(s) to release, indemnify, defend and hold harmless Holy Trinity Episcopal Day School, Episcopal Day School Board of Directors, and Holy Trinity Episcopal Church of Clemson, South Carolina, employees, members and agents of and from all liability, claims, demands, damages, injuries, costs, expenses, actions and causes of action caused, arising or to arise by reason of or during the child's participation in the program.

**Parent's/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_