Emergency Contact Information

Chelmsford High School Senior Capstone Experience

Student Name:_____

Date of Birth:_____

Address: _____

Home Phone: _____

Parent/Guardian Name: _____

Cell Phone _____

Home or work phone: _____

Name of person other than parent or guardian to contact in case of emergency:

1) Name: _____

Relationship: _____

Phone: (_____)_____

2) Name_____

Relationship _____

Phone: (_____)_____

Name of Family Physician/Pediatrician and Practice:
_____

Address: _____

Phone:_____

Medical Emergency Treatment Authorization

Chelmsford High School
Senior Capstone Experience

In the event of a medical emergency, every effort will be made to contact the parent/guardian immediately. If we cannot reach you, this completed form will authorize us to obtain the necessary medical treatment for said student.

Student Name:_____

I, _____of
(parent/guardian name)

_____am the legal parent/guardian
(Address)

of_____, a minor of

_____
(student address)

who is under the supervision of Chelmsford High School personnel through the Senior Capstone.

I hereby give my consent, in the event of all reasonable attempts to contact me at:

( ) _____ or ( )_____
(Phone Number) (# of other parent/guardian)

have been unsuccessful, for the administration of any treatment

deemed necessary by an available physician or any hospital reasonably accessible _____.
(preferred hospital)

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

_____
(Parent or Guardian Signature)

_____
(Date)