

**Parent(s)/Guardian(s):** *The following information is necessary to facilitate medical care for your child in the event of an emergency. This original form will be stored privately.*

**Student's Full Name:** \_\_\_\_\_

**Name(s) of:** (Please check one) Parent(s)  or Legal Guardian(s)

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone numbers where parent or guardian can be reached in the event of emergency:**

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ **Home Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**INFORMATION ABOUT THE STUDENT**

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Current Age:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Allergies: Food (nuts, etc.):** \_\_\_\_\_ **Insects/Animals:** \_\_\_\_\_

**Other Allergies:** \_\_\_\_\_

**Action(s) to be Taken in Case of Allergic Reaction(s):** EpiPen    Emergency Room

**Other:** \_\_\_\_\_

**Medications being taken & how often:** \_\_\_\_\_

**Date of last tetanus shot:** \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ **Doctor's Phone:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Medical Insurance Company:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Member's Full Name:** \_\_\_\_\_

I give permission for the student named above to be given appropriate medical treatment in the event of an emergency.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

Please give this form to your school coordinator, if applicable, or mail/fax to:

**TRISKELES: Mark Birdsall, Director of Youth Programs**

707 Eagleview Boulevard Suite 105, Exton, PA 19341

**Phone:** 610-321-9876 **Fax:** 610-321-0995 **Email:** mdbirdsall@triskeles.org **Website:** www.triskeles.org