



THE HARBOR SCHOOL

2008-2009 FIELD TRIP EMERGENCY CONTACT INFORMATION

Child's Name _____ Birth Date _____

Home Address _____

Mother's Name _____ Phone (H) _____ (W) _____

Father's Name _____ Phone (H) _____ (W) _____

Alternative Emergency Contact _____ Phone _____

Child's/Family Physician _____ Phone _____

Dentist _____ Phone _____

Known allergies of child (medicine, food, etc.) _____

Describe past serious illnesses or hospitalization, with dates _____

Medicine(s) taken by child _____

Date of last tetanus injection _____

Describe all physical conditions or illnesses which could affect the child's participation in the school's programs or the proper medical treatment (diabetes, epilepsy, etc.) _____

Health Insurance Company _____ Policy Number _____

2008-2009 EMERGENCY MEDICAL TREATMENT CONSENT

In the event I or my child's physician cannot be reached, I hereby authorize The Harbor School to transport my child to the emergency room of the nearest hospital, and I hereby grant my consent of the hospital and its medical staff to provide my child with emergency treatment which a physician deems necessary (including anesthesia). I understand that my child may be taken to and cared for at the nearest hospital. I agree to accept financial responsibility for all medical expenses incurred.

Parent/Guardian

Date

Parent/Guardian

Date