Emergency Medical Treatment Authorization

For students under the age of 18 D.O.B. _____

If you are OVER 18 years old COMPLETE the **d**ate **o**f **b**irth and name portion only.

Name of Student: _____
Last First Middle Initial

Parent/ Legal Guardian: _____
Last First Relationship to Student

Address: _____
Number Street Apt. Area Code/ Home Telephone

_____
City State Zip Area Code/ Business Telephone

In case of emergency, if unable to contact parent/guardian, please contact:

1. _____Telephone _____Relationship _____

2. _____Telephone _____Relationship _____

Student's Physician _____ Telephone _____

Student's Dentist _____ Telephone _____

If student is taking any regularly prescribed medication, is allergic to any medication, or there is any other emergency information we need to know, please indicate below:

_____

_____

In the event of an accident or illness, I hereby grant permission to authorized Columbus State Community College personnel to authorize first aid to my son/daughter.

Signature of Parent/Guardian _____

Date _____

In the event of an emergency, if reasonable attempts to contact those named above prove unsuccessful, I hereby give consent to transport my son or daughter to the Emergency Medical Department of the nearest hospital. If his/her physician cannot be contacted, medical treatment deemed necessary by the attending licensed physician or dentist may be administered.

Signature of Parent/Legal Guardian _____

Date_____