

**Harrison County Board of Education  
Emergency Medical Treatment**

School Copy

Student's Name: \_\_\_\_\_  
Last First

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

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

Home Phone: ( ) \_\_\_\_\_

Father Work Phone: ( ) \_\_\_\_\_ Father Cell Phone: ( ) \_\_\_\_\_

Mother Work Phone: ( ) \_\_\_\_\_ Mother Cell Phone: ( ) \_\_\_\_\_

Is student allergic to any medicine or drug? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Has student had tetanus shot? Yes \_\_\_\_\_ No \_\_\_\_\_ When: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Medicines being taken: \_\_\_\_\_ Religion: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Physician Office Phone: ( ) \_\_\_\_\_

Instructions for emergency medical treatment: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

For the parent/guardian: I hereby grant permission for the above to participate in extra-curricular activity. In the event of accident or medical illness, permission is granted for any such medical and/or surgical treatment as may be necessary. Every effort will be made to notify me before any major treatment is undertaken.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Harrison County Board of Education  
Emergency Medical Treatment**

Chaperone Copy

Student's Name: \_\_\_\_\_  
Last First

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

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

Home Phone: ( ) \_\_\_\_\_

Father Work Phone: ( ) \_\_\_\_\_ Father Cell Phone: ( ) \_\_\_\_\_

Mother Work Phone: ( ) \_\_\_\_\_ Mother Cell Phone: ( ) \_\_\_\_\_

Is student allergic to any medicine or drug? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Has student had tetanus shot? Yes \_\_\_\_\_ No \_\_\_\_\_ When: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Medicines being taken: \_\_\_\_\_ Religion: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Physician Office Phone: ( ) \_\_\_\_\_

Instructions for emergency medical treatment: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

For the parent/guardian: I hereby grant permission for the above to participate in extra-curricular activity. In the event of accident or medical illness, permission is granted for any such medical and/or surgical treatment as may be necessary. Every effort will be made to notify me before any major treatment is undertaken.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date