

DEPARTMENT OF EDUCATION OF THE CITY OF NEW YORK

STUYVESANT HIGH SCHOOL

345 Chambers Street, New York, NY 10282

Telephone: (212) 312-4800 • Facsimile: (212) 587-3874

Jie Zhang, Principal

**CONFIDENTIAL MEDICAL INFORMATION AND EMERGENCY
NOTIFICATION FORM (STUDENT)**

PLEASE PRINT CLEARLY

Name: _____ Birth date (MM/DD/YY): _____

SEX: M F (circle one)

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____

Date of Last Tetanus Shot: _____

Drug Allergies: _____

Physician: _____ Physician's Phone: () _____

Regular Medications: _____

Special Dietary Requirements/Food Allergies: _____

EMERGENCY NOTIFICATION INFORMATION

Father's Name: _____ Home Phone: () _____

Cell Phone: () _____

Mother's Name: _____ Home Phone: () _____

Cell Phone: () _____

Legal Guardian: _____ Home Phone: () _____

Cell Phone: () _____

Preferred Emergency Contact: _____

Relationship to Student: _____

Medical/Hospital Insurance Carrier: _____

Policy Number: _____

Insurance Carrier Phone: () _____

CONSENT TO MEDICAL CARE AND TREATMENT

(Parental consent is required before a hospital's emergency department can give medical treatment to a minor. Every effort will be made to contact the parents/guardian, but a completed consent form will expedite treatment).

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to my child by a licensed physician(s) or hospital if attempts to contact me have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatment(s).

I also warrant that the major medical health insurance listed above covers my child for all activities and in all jurisdictions associated with this trip. I understand that I am responsible for the cost of all emergency medical care provided including any deductible or treatment denied by my carrier for any reason.

Signature of Parent or Legal Guardian: _____ Date: _____

NOTARY PUBLIC SIGNATURE

Stamp: