

**VSJC EMERGENCY MEDICAL INFORMATION**

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

Birth Date: \_\_\_\_\_

Please list any allergies, medications, medical conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION:**

Carrier: \_\_\_\_\_

Policy #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:**

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

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

**Physician:** \_\_\_\_\_

Phone: \_\_\_\_\_

**MEDICAL RELEASE:**

In the event of accident, injury, or illness, and if reasonable efforts to contact me have failed, I hereby give attending physicians or authorized medical personnel consent and permission to provide: *(student name)*

\_\_\_\_\_ with necessary medical treatment.

*Signature of parent or legal guardian*

\_\_\_\_\_

Date: \_\_\_\_\_