

ESP Emergency Medical Form

This information is required from the parent/guardian of a child/children enrolled in E.S.P. Should your child become ill and require medical attention by the E.S.P. staff or EMT personnel and/or transportation to a local health care facility, the following information will be very helpful to the medical personnel:

Child's Name: _____ Age: _____ D.O.B. _____

Parent/Legal Guardian: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Child's physician: name, address, phone _____

Is your child allergic to any medications or other items: If so, please explain: _____

Explain other health conditions, which would be valuable, helpful information to medical personnel: _____

In the event your child becomes ill or injured every effort will be made to notify the parents. In case the parents cannot be reached, please provide the following information.

Name, relationship, and phone number of relatives or other person to contact in an emergency:

Insurance information:

Name of insured _____ Carrier Name: _____

ID no. _____ Group no. _____

I understand that by signing this, the E.S.P. staff is granted permission to provide emergency treatment to my child. Additionally EMT's or other medical personnel are granted permission to provide medical treatment as well.

Parent/Guardian's Signature Required: _____

Date: _____