chinmaya mission san jose

STUDENT MEDICAL FORM

This form must be completed prior to treating a child.

In case of emergency, _____has my consent to authorize medical care for my child listed below:

STUDENT'SNAME_____DATE_____

BIRTHDATE_____ AGE_____Male_____ Female _____

Our family physician is: _____

His/her address is: _____

His/her telephone # is: _____

Our hospital preference is: _____

Allergies: _____

Contact me immediately at: _____

If unable to contact me, please call:

_____@_____
Name Telephone

_____@_____
Name Telephone

Signed by

Name: _____

Address: _____

Telephone: _____ Date: _____