

## Medical Information Form

**In case of emergency, I understand that every effort will be made to contact me. If I cannot be reached, I hereby give Northwest Home Educators Co-op of San Antonio, Texas permission to act on my behalf in seeking emergency treatment for my child in the event that such treatment is deemed necessary by NWHE Co-op. I give permission to those administering emergency treatment to do so using measures deemed necessary. I absolve NWHE Co-op and Northwest Community Church from liability in acting on my behalf.**

Student: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Parents: \_\_\_\_\_

Phone Number: \_\_\_\_\_ or \_\_\_\_\_

Alternative Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Allergies: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Medications: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Parent signature: \_\_\_\_\_