

2015 - 2016

Doris Todd Christian Academy  
EMERGENCY TREATMENT FORM

One Form per Student – Please Print Clearly

Student's Full Legal Name \_\_\_\_\_ Grade \_\_\_\_\_  
Last First Middle

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_

Medical Plan \_\_\_\_\_ Policy # \_\_\_\_\_ Med Record # \_\_\_\_\_

Physician's Name \_\_\_\_\_ Clinic Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Significant History (allergies, asthma, diabetes, recommendations, etc.) \_\_\_\_\_

Father's Name \_\_\_\_\_ Workplace \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Workplace \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work phone \_\_\_\_\_

**IF PARENTS CANNOT BE REACHED, CALL:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work phone \_\_\_\_\_

If I am unable to be contacted, Doris Todd Christian Academy staff has my permission for \_\_\_\_\_  
to receive emergency care at a hospital or emergency center. Student's Name

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PERSONS AUTHORIZED TO PICK-UP STUDENT(S) FROM SCHOOL**

NAME	ADDRESS	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**I/We agree to inform DTCA if we decide to add or delete anyone from this list.**

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_