

MOUNT DE CHANTAL VISITATION ACADEMY

410 Washington AVE

Wheeling, WV 26003

304-233-3771

304-233-8598 (fax)



Emergency and Illness Information Personal Data

Student Name _____

Parent/Guardian Name _____

Home Address _____ County _____

City _____ State _____ Zip _____ Telephone _____

Date of Birth _____ Social Security # _____

Age on 9/1/06 _____ School District _____

Parent/Guardian Emergency Contact	Parent/Guardian Emergency Contact
Name:	Name:
Relationship:	Relationship:
Numbers we can call:	Numbers we can call:
Home	Home
Work	Work
Cell Phone	Cell Phone
Beeper	Beeper
Email	Email



Persons to contact in an Emergency – Other than Parents

Contact Next	Contact Next
Name:	Name:
Relationship:	Relationship:
Numbers we can call:	Numbers we can call:
Home	Home
Work	Work
Cell Phone	Cell Phone
Beeper	Beeper
Email	Email

Please complete the reverse side!!!

Health Information



Are there any unusual health conditions?

Asthma _____	Bee Sting Allergy _____	Internal Irregularities _____
Arthritis _____	Other Allergies _____	Convulsive Disorders _____
Diabetes _____	(list) _____	Sight Impairment _____
Dental Appliances _____	Deafness _____	Wears glasses/contacts _____
Fractures _____	Heart _____	Kidney/Bladder _____
Physical Disability or any other conditions that the school should know about: _____		

Physician, Dental, and Hospital Information

Doctor _____	Phone Number _____
Address _____	
Dentist _____	Phone Number _____
Address _____	
Preferred Hospital _____	Phone Number _____
Address _____	



Emergency Treatment Release Form

Part I – To Grant Consent

In the event that reasonable attempts to contact all persons listed have failed, I hereby give my consent to the administration for treatment deemed necessary by the doctor or dentist referred to on this form. In the event the designated preferred practitioner is not available, treatment may be provided by another licensed physician or dentist. Permission is also given for the transfer to the hospital listed on this form or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two licensed physicians or dentists are obtained and concur in the necessity for surgery prior to the performance of such surgery. Facts concerning medical history, including allergies, medications being taken, and any physical impairments to which a physician or dentist should be alerted are listed on this form.

Signature of Parent/Guardian Date

Part II – Refusal to Consent

I do not give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish school authorities take no action or to do the following:

Signature of Parent/Guardian Date