

SUMMIT CHAPERONE EMERGENCY INFORMATION

Trip to: _____ Date/s: _____

Name: _____ **Date of birth:** _____

ALLERGIES: _____

Special Health Concerns/Past Surgeries: _____

Medications routinely taken: _____

EMERGENCY CONTACTS:

Contact #1 Name: _____ #2 Name: _____

Home phone: _____ Home phone: _____

Work phone: _____ Work phone: _____

Cell phone: _____ Cell phone: _____

Medical insurance carrier and policy
number: _____

Health care Provider: Name: _____

Address: _____ Phone: _____

I give consent for emergency treatment including:

1. Administration of any emergency treatment deemed necessary by a licensed physician, dentist or other health care provider;

and transfer to any hospital reasonably accessible.

This authorization does not cover invasive surgery unless the medical opinions of two licensed physician's concurring on the

necessity of such surgery are obtained prior to the performance of such surgery.

To the best of my knowledge all of the above information is accurate and complete.

To comply with privacy regulations, Summit School will only disclose Protected Health Information (PHI) to outside agencies with written authorization.

X. Signature: _____

Date: _____

This information will be destroyed immediately following the trip's completion.