

EMERGENCY CARD
Must be completed for application to be accepted.

Child's Name _____ Birth Date _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Parent 1 Name _____ Parent 2 Name _____

Cell Phone _____ Cell Phone _____

Person other than parents to be notified in an emergency when the parents are not available.

Name _____ Relationship _____

Cell Phone _____

Person(s) other than parents to whom the child may be released.

Name _____ Relationship _____

Name _____ Relationship _____

Child's Specific Medical Information

Allergies _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Medication _____ Frequency _____

Other _____

Physician _____ Phone # _____

Address _____

Health Insurance Company _____

(Please send a copy of the insurance card along with this form.)

Policy Holder _____ Policy # _____

Address _____ Phone _____

I hereby give permission to Colorado State University to secure emergency medical and/or surgical treatment for the above named minor child while in the care of the above named school. All expenses of such care will be accepted by the parents or legal guardians of the above named minor child.

Signature of parent or legal guardian

Date