ALBANY HIGH SCHOOL
CAREER AND TECHNICAL EDUCATION
99 Kent Street • Albany, New York 12206 • 518-475-6400 • www.ahscte.com

Work Based Learning: Emergency Medical Treatment

Name of student: _____ Student ID#: _____

Parent/Legal Guardian: _____ Relationship: _____

Telephone: H: _____ W: _____ C: _____

Address: _____

_____

In case of emergency, if unable to contact parent/guardian, please contact:

1. _____ Telephone: _____ Relationship: _____

2. _____ Telephone: _____ Relationship: _____

Student's Physician: _____ Telephone: _____

Student's Dentist: _____ Telephone: _____

If student is taking any regularly prescribed medication, is allergic to any medication, or if there is any other emergency information we need to know, please indicate below:

_____

_____

In the event of an accident or illness, I hereby grant permission to authorized personnel to provide for first aid to my son/daughter in the event of an emergency if reasonable attempts to contact those named above prove unsuccessful. I hereby give consent to transport my son or daughter to the Emergency Medical Department of the nearest hospital. If his/her physician cannot be contacted, medical treatment deemed necessary by the attending licensed physician or dentist may be administered.

Signature of Parent/Legal Guardian: _____

Name of Parent/Legal Guardian: _____

Date: _____