

Palm Beach State College
Student Emergency Contact and Medical Treatment Form

PERSONAL INFORMATION

Name: _____ Student ID#: _____

Address: _____

Primary Phone #: _____ Secondary Phone #: _____

EMERGENCY CONTACT

Name: _____ Relation to Student: _____

Primary Phone# _____ Secondary Phone # _____

Address: _____

Email: _____

EMERGENCY MEDICAL INFORMATION

Please type in "Y" next to any of the following that apply to you:

Allergies:	Asthma:	Diabetes:
Fainting Spells:	Convulsions:	Bleeding
Wear Contact Lenses:	Wear Dentures:	Have a Pacemaker

Other (Specify any other medical conditions or information):

PERMISSION FOR EMERGENCY TREATMENT

I/We authorize the appointed representative(s) of Palm Beach State College to obtain and authorize medical treatment as is necessary to protect the student's well-being, including authorization for emergency treatment, anesthesia, and/or surgery as deemed necessary. Further, I/we do hereby release and agree to hold Palm Beach State College, employees, administrators, agents and Board of Trustees harmless from any and all claims and causes of action which might be brought by myself, parents, spouse, dependents, heirs, executors and administrators for loss of property, personal injury or death sustained by the student arising out of any travel or activity conducted by or under the control of Palm Beach State College.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____