

HSPVA Student Emergency Contact and Medical Information

As per HISD requirements, this form **MUST** be completed and **NOTARIZED** (see page 2) in order for your student to attend an Art Department Field Trip.

Ms. Lisa Clark, in the Main HSPVA office is a NOTARY and will be happy to assist you with this process if you cannot take the form to an outside Notary.

Student's Name (Last, First, Middle) _____ Date of Birth _____ M F
Sex

GRADE 9 10 11 12

Parent's/Guardian's Name (person(s) with whom you live) _____

() _____
Home Phone Work Phone
() _____
Cell Phone Other

Parent's/Guardian's Name (person(s) with whom you live) _____

() _____
Home Phone Work Phone
() _____
Cell Phone Other

Address _____

City ST ZIP Code

Address _____

City ST ZIP Code

Alternative Emergency Contacts: ABSOLUTELY REQUIRED

Primary Emergency Contact _____

() _____
Home Phone Work Phone
() _____
Cell Phone Other

Secondary Emergency Contact _____

() _____
Home Phone Work Phone
() _____
Cell Phone Other

Address _____

City ST ZIP Code

Address _____

City ST ZIP Code

Medical Information

Hospital/Clinic Preference _____

Physician's Name _____

() _____

Phone Number

() _____

Phone Number

Allergies/Special Health Considerations (ex. diabetes, asthma, high blood pressure, allergies, insomnia, etc.)

Date of Last Tetanus Vaccination (if known) _____

Medication that you must take regularly (Please note that if you will need TO BRING medication ON a Field Trip, it **MUST** be given to an instructor and **MUST** include instructions for administering this medication, which **MUST** be in the **ORIGINAL CONTAINER**.)

Name of Medication _____ Dose _____

Directions for administering medication _____

Name of Medication _____ Dose _____

Directions for administering medication _____

Medication to which you are allergic _____

Do you wear glasses or contact lenses? _____

In the Event of an Emergency, Parents Will Be Contacted!

If my son/daughter (name) _____ should become ill or is injured while at HSPVA, or while traveling to or from a Field Trip Destination, I give my consent to the hospital personnel for examination and treatment of him / her. I will be responsible for all debts incurred while treating him/her.

Signature of Parent/Guardian

Medical Insurance Carrier _____ Group Insured Name _____
I.D. Number _____ Phone Number _____



THE STATE OF TEXAS, COUNTY OF HARRIS

BEFORE ME, THE UNDERSIGNED AUTHORITY, ON THIS DAY PERSONALLY APPEARED _____ KNOWN TO ME TO BE THE PERSON WHO SIGNED THE FOREGOING DOCUMENT IN MY PRESENCE, AND WHO, UPON OATH STATED THAT SUCH DOCUMENT WAS EXECUTED FOR THE PURPOSE AND CONSIDERATION THEREIN CONTAINED.

SUBSCRIBED ON THIS, THE _____ OF _____, 20 _____

_____, NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS.

MY COMMISSION EXPIRES: _____