Emergency Medical Information
VISIONS OF TRUTH COMMUNITY DEVELOPMENT CORPORATION
Students Taking Responsibility in Valuing Education
STRIVE PROGRAM

Participant Name: _____ DOB: _____

Physicians Name: _____ Phone number: _____

Food Allergies: _____ Other Allergies: _____

Please list all prescription drugs including inhalers, etc.

Drug	Dosage	Times of administration
1.		
2.		
3.		

The program director is certified to administer medication to participants. I am requesting that the director provide the scheduled dosages to my child during program hours.

Parent/Guardian Signature: _____ Date: _____

In case of emergency, I prefer my child to be transported to _____Hospital emergency room. State law requires transportation to the nearest facility in life threatening situations.

Parent/Guardian Signature _____ Date _____