STUDENT MEDICAL EMERGENCY INFORMATION

Student's Name: _____ Grade & HR Teacher _____

Date of Birth: _____ Primary Email: _____

Please indicate the order of preference you wish the school to contact:

Mother's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Father's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Student Insurance Verification

Name of Health Insurer: _____ Student's Physician: _____

Policy # _____ Physician's Phone: _____

Expiration Date: _____

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

I, _____, the parent or guardian of _____,

recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance.

Please make the following notation on my child's records:

- Allergies to medications/foods/latex/insect stings & bites/other: _____

_____

_____

- Chronic conditions (indicate medication & condition): _____

_____

_____

- Relevant medical information (e.g., contact lens wearer, seizures, heart conditions, asthma, surgeries): _____

_____

_____

I give the school permission to share this information to protect the health or safety of my child or others.

_____ _____

Signature of Parent or Legal Guardian Date

- It is the parent's responsibility to keep all information current throughout the school year.
- May Tylenol (regular strength) be given during the school day? Yes _____ No _____
- _____ does not employ a school nurse to administer medication.