

STUDENT MEDICAL/EMERGENCY INFORMATION

Student's Name: _____ Grade: _____

E-mail Address: _____ Homeroom Teacher: _____

In case of an emergency, we will try to contact the parents first. If we cannot reach them please list several contact persons below in the order you wish them to be contacted.

Name	Relationship	Contact Numbers
_____	_____	(h) _____ (w) _____ (c) _____
_____	_____	(h) _____ (w) _____ (c) _____
_____	_____	(h) _____ (w) _____ (c) _____
_____	_____	(h) _____ (w) _____ (c) _____

Student Insurance Verification

Name of Health Insurer: _____ Policy #: _____

Physicians Name: _____ Phone #: _____

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 NOTATIONS 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, previous surgeries): _____

I give the school permission to share this information to protect the health or safety of my child or others. I understand it is my responsibility to keep all information current throughout the entire school year.

Signature

Date

May aspirin-free pain reliever be given during the school day? Yes _____ No _____

Unless indicated, dosage will be given by weight recommendations.