EMERGENCY HEALTH INFORMATION

Student Name: _____ Grade: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City/State/Zip: _____

Father/Male Guardian: _____ Cell Phone: _____

Address (if different from above): _____

Mother/Female Guardian: _____ Cell Phone: _____

Address (if different from above): _____

Emergency Contact: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

MEDICAL HISTORY

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your student is subject and of which the staff should be aware of.

Check the following areas of concern for this student. If necessary, add another page with details.

1. Does this student have allergies to:
   ☐ pollens ☐ medications ☐ food ☐ insect bites
   Please explain: _____

2. Does this student suffer from, or has ever experienced, or is being treated currently for any of the following:
   ☐ asthma ☐ medications ☐ heart trouble ☐ diabetes
   ☐ frequently upset stomach ☐ physical handicap ☐ epilepsy/seizure disorder

3. Should this student's activities be restricted for any reason? Please explain: _____

4. Does this student take daily medication? ☐ yes ☐ no If yes, please explain _____

5. Does this student wear: ☐ glasses ☐ contact lenses

6. Other (please explain): _____

Family Physician: _____ Office Phone: _____

Family Dentist: _____ Office Phone: _____

MEDICAL CONSENT TO TREAT

In the event of serious illness or injury, I/we give consent for my/our child to be taken to our doctor's office or the closest hospital by school personnel or ambulance, and emergency care provided there, until I can be contacted. My child is eligible for medical care through _____
Insurance Company and Policy Number

I agree to pay for any charges and activity to secure emergency medical treatment for my child. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health and/or dental insurance.

Permission is hereby granted to the School Administrator or authorized designee to administer the following over-the-counter medications:

Ibuprofen (Advil, Nuprin, etc.): ☐ YES ☐ NO Acetaminophen (Tylenol): ☐ YES ☐ NO

_____ _____
Signature of parent/guardian Date