

Medical Information/Emergency Release Form

Student's legal name _____ Prefers to be called _____

Home phone: _____ Date of birth ___/___/___ Grade _____ Gender (please circle): M F

Address _____ City _____ State _____ Zip Code _____

Parent information:

Mother: _____ work _____ cell _____

Father: _____ work _____ cell _____

Step-parent: _____ work _____ cell _____

	Name	Phone
Pediatrician/primary care provider		
Dentist		

Insurance Company: _____

Policy number _____ Phone _____

Emergency contact who will assume responsibility if parent cannot be reached:

Name: _____ home _____ cell _____

Name: _____ home _____ cell _____

Date of last tetanus shot: _____

(In case of accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)

I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

Parent/guardian signature: _____ **Date** _____

Medical History

Name _____

Please indicate below (X) if your student has any of the following, and describe any treatments/medications, or special considerations:

- Asthma (worsened by exercise? Y N) (*Inhaler? Y N)
- Allergies (list all) _____ (*EpiPen? Y N)
- Cardiac Issues
- Diabetes
- Gastrointestinal Issues
- Hearing Issues
- Kidney/Bladder Issues
- Migraines
- Orthopedic Issues
- Seizures
- Vision Issues (glasses/contacts/other _____)
- Other (list: _____)

***If your child requires having an inhaler and/or EpiPen at school, please have your physician complete the authorization form/treatment plan; these can be found on the website or obtained from the school nurse.**

Surgical history: Type(s) _____ Year(s) _____

Disabilities or restrictions: _____

Monitoring devices or medical equipment to be used while at school? _____

Medications your student takes regularly: _____

Any other information about your child that would be helpful for the school nurse to know:

No medications (over the counter or prescription) will be administered by the school nurse, other school personnel, or self-administered by the student without the written authorization of a parent and physician/authorized provider. All prescription medications must be brought to school in the original container with the student's name and prescription information on the label.

All over-the-counter medication dosages will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. These forms will also be the authorized form used for off campus activities, including overnight trips.

Parent/guardian signature _____ Date _____