STUDENT MEDICAL – EMERGENCY FORM

Student Name: ____Grade______ Teacher____________________

Student Name: ____Grade______ Teacher____________________

Student Name: ____ Grade______ Teacher____________________

Student Name: ____ Grade______ Teacher____________________

Student Name: ____ Grade______ Teacher____________________

Home Address:___________________________________City____________________ Zip: ___________ Phone:____________

Father's Name ______________________________________Cell Phone #:____________________Work Phone #:_____________

Mother's Name______________________________________ Cell Phone #:____________________Work Phone #:____________

EMERGENCY CONTACT INFORMATION

In case of emergency if parent/guardian cannot be reached, the school has my permission to contact the following:

Name:__________________________________Relationship:_________________________Phone :_______________________

Name:__________________________________Relationship:_________________________Phone :_______________________

Family Physician's Name: ____Phone:________________________

INSURANCE VERIFICATION

Name of my Health /Accident Insurance Company: ____

Policy holder's name:___________________________________ Relationship to student:_________________________________

Policy #____Date of Expiration ___________________________________

MEDICAL EMERGENCY TREATMENT CONSENT

Please initial each statement to verify your agreement.

______I recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary.

______I further recognize that school personnel may be unable to contact me for my consent for emergency medical care.

______I do hereby consent to such emergency care in advance, including hospital care as may be deemed necessary by the physician selected by the school for my student(s) named above.

______ I understand that the school does not assume responsibility for payment of a physician in any case.

______ I agree that in an emergency the school may choose a physician.

KNOWN MEDICAL CONDITIONS

Initial all that apply by Student.

	Asthma	**Diabetes**	**Heart Murmur**	**Epilepsy**	**Glasses/ Contact Lens**	**Other**
Name of student: ____________________	______	______	______	______	______	______
Name of student: _____________________	______	______	______	______	______	______
Name of student: ____________________	______	______	______	______	______	______

ALLERGIES
Please initial each item that applies:

	Food	Asthma	Seasonal (hay fever, mold, etc.)
Name of student: _____________________	______	______	______
Name of student: _____________________	______	______	______
Name of student: _____________________	______	______	______
Name of student: _____________________	______	______	______

NON-EMERGENCY TREATMENT
Please initial to verify your agreement:

______I authorize the school to provide recommended doses of the following basic over-the-counter remedies to treat my child's illness or injury without having to contact me prior to each incident.

- For minor cuts, scrapes, insect bites, etc.:

Please initial each item to verify your agreement.

______ Hydrogen Peroxide ______ Alcohol Pad _____ First-Aid Ointment ______ Cortisone Ointment
______ Benadryl Ointment ______ Bandaids/Wrappings

- For fever and minor aches and pains, etc.:

Please initial each item to verify your agreement:

_____ Child's Ibuprofen (i.e. Motrin, Advil, etc.) ______ Child's Acetaminophen _____ Adult Ibuprofen
______Adult Acetaminophen ______ Cough Drops ______ Throat Lozenges ______Eye Drops

OTHER

PLEASE NOTE ANY OTHER MEDICAL INFORMATION/CONDITIONS THAT IS PERTINENT REGARGING THE HEALTH OF YOUR STUDENT(S):

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Signature of Parent:____ Date:_______________________
(or Guardian)