Medical Emergency Information

Student's Name ______________________ ______________________ ____________
Last First Middle

Address __________ ______________________________ __________
House No. Street Name Apt. No.

______________________ ______________________ __________
City State Zip Code

Grade ____________ Date of Birth ____________________

Student Lives With:

❑ Both Parents ❑ Mother Only ❑ Father Only ❑ Grandparent(s) ❑ Other ____________________

Emergency Contact (1) ____________________________ Relationship ____________

Work Phone ____________ Cell Phone ____________ Alternate # ____________

Emergency Contact (2) ____________________________ Relationship ____________

Work Phone ____________ Cell Phone ____________ Alternate # ____________

Physician's Name ____________________________ Phone No. ____________

Please list any allergies that affect your child: ____________________________

Indicate any other health condition(s) your child has in which the school should know about. Include any health conditions that may require special attention from the school.

Does your child take any medication regularly? ____________________________

Authorization: I give my permission for the school to administer the following over-the-counter medications to my child: ❑ Tylenol ❑ Benadryl ❑ Ibuprofen ❑ Fluoride Mouth Rinse

Note: *To be administered at school, all prescription medications must be accompanied by a physician's note, a parental consent form, and in an original pharmacy container. Forms are available in the school's office. If the school is unable to* contact me in the case of a serious medical emergency, I authorize the school to provide the necessary emergency medical services.

______________________________ ____________

Parent/Legal Guardian's Signature Date