

EMERGENCY & HEALTH INFORMATION FORM

LAST NAME _____ FIRST NAME _____ D.O.B. _____
PARENT/GUARDIAN NAME _____ HOME PHONE _____
HOME STREET ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
MOTHER'S WORK PHONE _____ CELL PHONE _____
FATHER'S WORK PHONE _____ CELL PHONE _____

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE CONTACT:

NAME _____ ADDRESS _____
PHONE _____ RELATIONSHIP TO STUDENT _____

NAME _____ ADDRESS _____
PHONE _____ RELATIONSHIP TO STUDENT _____

PROFESSIONAL CONTACTS:

STUDENT'S PHYSICIAN _____ PHONE _____

STUDENT'S DENTIST _____ PHONE _____

HOSPITAL STUDENT SHOULD BE TAKEN IF PARENT OR PHYSICIAN UNAVAILABLE

ALLERGIES & MEDICAL CONDITIONS (Please explain checked items below. If necessary, use other side.)

ALLERGIES ASTHMA DIABETES OTHER
 EPILEPSY HEART PROBLEMS RECURRING/CHRONIC ILLNESS

MEDICATIONS: (LIST ALL MEDICATIONS STUDENT TAKES REGULARLY INCLUDING OVER-THE-COUNTER MEDS)

MEDICINE _____ DOSE _____ FREQUENCY _____

MEDICINE _____ DOSE _____ FREQUENCY _____

ANY MEDICATIONS THAT WILL BE TAKEN WHILE STUDENT IS AT THE SCHOOL MUST BE CHECKED IN AT THE OFFICE IN ITS ORIGINAL PACKAGING INCLUDING OVER-THE-COUNTER MEDICATIONS WITH THE STUDENT'S NAME PERMANENTLY ATTACHED. Medications may only remain with a student with a written physician's request or for students 18 and older. Those students are not permitted to share their medication of any kind with any other students.

LIST MEDICATIONS THAT CANNOT BE TAKEN _____

PARENT Use the back of form for any additional information or comments.

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may take whatever actions seem necessary.

PARENT SIGNATURE: _____ DATE: _____