ARTHUR COMMUNITY UNIT SCHOOL DISTRICT #305
EMERGENCY MEDICAL FORM

Student's Name_____ Grade _____
Date of Birth: _____ Physician: _____ Hospital: _____

CONTACT NUMBERS: (parents/guardians will be called first, please give alternate contacts)
Name: _____ Daytime Phone: _____
Relationship to Student: _____ Cell Phone: _____

Name: _____ Daytime Phone: _____
Relationship to Student: _____ Cell Phone: _____

Please list facts concerning the child's medical history including ALL allergies, medications being taken, and any physical impairments to which physicians and school employees should be alerted to protect the student's health and safety.

PLEASE CIRCLE YES OR NO:			**DETAILS:**
Diagnosis of asthma	Yes	No	___Inhaler ___Nebulizer ___Peak Flow Meter
Birth defects	Yes	No	
Blood Disorders	Yes	No	___Sickle Cell ___Hemophilia
Diabetes	Yes	No	
Seizures	Yes	No	
Heart problems	Yes	No	
Eye/Vision problems	Yes	No	___ Glasses ___Contacts
Ear/Hearing problems	Yes	No	___ Hearing aids
Dental problems	Yes	No	___ Braces ___Bridges
Bone/Joint problems	Yes	No	___ Scoliosis
Hospitalizations – when and what	Yes	No	
Surgery – when and what	Yes	No	
Serious injury or illness	Yes	No	
ADD/ADHD	Yes	No	
Depression/Bipolar disorder	Yes	No	
Anxiety	Yes	No	
Dietary Restrictions	Yes	No	
ALLERGIES: Bees/Environmental/Medication/Food	Yes	No	

MEDICATIONS: (include medications taken both at home and school)

_____ _____
_____ _____
_____ _____
_____ _____

Signature of Parent/Guardian: _____

Date: _____