EMERGENCY HEALTH INFORMATION

Student Name:____ Grade: ___________________

Home Address:____ Phone:___________________

WHEN PARENTS CANNOT BE LOCATED, WHOM SHOULD WE CONTACT LOCALLY?

Name:______________________________Relationship:___________________ Phone:___________(H)

___________(C)

Name:______________________________Relationship:____________________Phone:___________(H)

___________(C)

To best serve your child in case of an accident or sudden illness, it is necessary that we maintain a current and up-to-date health record.

Allergies:____________________ Eczema Skin Condition: _________ Seizures:___________________

Arthritis:____________________ Heart Condition: _______________ Hearing Impairment:__________

Asthma:_____________________ Kidney/Bladder:________________ Hearing Aid:________________

Bee Sting Allergy: _____________Menstrual Problems:____________ Vision Impairment:__________

Congenital defects:___________ Physical Handicap: _____________ Contacts:___________________

Diabetes:____________________ Other medical:____

Does your child take medication?__________ If yes, list medication and dosage:______________________

Reason for medication:____

MEDICAL INFORMATION TO BE SHARED WITH TEACHERS AND STAFF:______________________________

____

NO MEDICATIONS WILL BE GIVEN WITHOUT WRITTEN CONSENT. School personnel are not allowed to accept verbal consent or instructions.

IF A DOCTOR'S CARE IS NECESSARY, MAY WE CALL YOUR DOCTOR?_________

Name of Physician:_______________________________________ Phone:_________________________

IN CASE OF SERIOUS INJURY OR ILLNESS, I GIVE MY PERMISSION FOR THE ABOVE NAMED STUDENT TO BE TREATED BY LOCAL EMERGENCY PERSONNEL.

Parent /Guardian Signature:____ Date:__________________