EMERGENCY MEDICAL INFORMATION FORM

Name: _____ DOB: _____

Address: _____ Home Phone: _____

Health Insurance (attach a copy of insurance card or complete the following):

Name of Insurance Company_____ ID Number: _____ Group Number:_____

Allergies (medications, insects, food etc.)

Dietary Restrictions:

List and describe any current medical issues concerning your child that should be shared with the chaperoning teacher(s) and emergency medical personnel.

Current Medications: **List all medications the student will be taking while on this trip** in the space provided below. Attach the completed Authorization for the Administration of Medicine form for **EACH** prescription medication and/or the completed Over-The-Counter Medication Order form.If you have a medication order on file for **AS NEEDED** medications such as an Epi Pen or Inhaler you do not need a second form. You will need a second form for **DAILY** medications.

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name	Relationship	Home Phone	Work Phone	Other Phone
1.				
2.				
3.				

_____

Parent/Guardian Signature Date

Rev 10/25 col

Return completed form to school nurse office