MEDICAL & EMERGENCY NOTIFICATION INFORMATION ~ AUTHORIZATION FOR MEDICAL TREATMENT

To be completed by parent/guardian for each child and submitted to the school annually.
THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS.
IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.

STUDENT NAME_____ **Birthdate** ___/___/___ **2019-2020**

(**PLEASE PRINT ON THIS FORM**) **COUNTY** _____ **Grade** _____ **Room #** _____

Our Lady of the Wayside School

Health Information: Please mark the appropriate boxes regarding your child's health history.

- ❑ Is an Emergency Action Plan needed for school? (yes)_____ (no)_____
- ❑ Allergies: Insect/food/medicine? _____
  Epi-pen? (yes)_____ (no)_____
- ❑ Asthma: Limitations? _____
  Inhaler used? (yes)_____ (no)_____
- ❑ Epilepsy/Seizures _____
- ❑ Diabetes_____
- ❑ Heart Condition: Restrictions? _____
- ❑ Stomach or bladder problems _____
- ❑ Takes daily-prescribed medication: What type? _____
  Will this be taken at school? No_____
  Yes_____(request for medication form necessary)

Other pertinent health information (ie: recent surgery / fainting / etc.) that school should know about: _____

_____

EMERGENCY CONTACTS: (List #1. and #2. in order of preference to call)

1. Parent/Guardian_____
Address _____
Home Phone (___) _____
Cell Phone (___) _____
Work Phone (___) _____

2. Parent/Guardian_____
Address _____
Home Phone (___) _____
Cell Phone (___) _____
Work Phone (___) _____

Child lives with: Both Parents _____ Mother only _____ Father only _____ Joint _____ Other _____

Name of Student's Physician _____ Phone (___) _____

Medical Insurance Provider _____ Policy /Insurance # _____

OTHER LOCAL PEOPLE TO CALL IN CASE PARENT/GUARDIAN CANNOT BE REACHED: (please list two in order)

1st Contact Name _____
Relationship to student _____
1st Phone number (___) _____ (h c w)
2nd Phone number (___) _____ (h c w)
Circle: home/cell/work

2nd Contact Name _____
Relationship to student _____
1st Phone number (___) _____ (h c w)
2nd Phone number (___) _____ (h c w)
Circle: home/cell/work

MEDICAL RELEASE In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or for medication deemed necessary.

×_____ ×_____
PARENT/GUARDIAN SIGNATURE DATE

×_____ ×_____
PARENT/GUARDIAN SIGNATURE DATE