

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** ____/____/____

2020-2021

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

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 _____	2. Parent/Guardian _____
Address _____	Address _____
Home Phone (____) _____	Home Phone (____) _____
Cell Phone (____) _____	Cell Phone (____) _____
Work 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)

1 st Contact Name _____	2 nd Contact Name _____
Relationship to student _____	Relationship to student _____
1 st Phone number (____) _____ (h c w)	1 st Phone number (____) _____ (h c w)
2 nd Phone number (____) _____ (h c w)	2 nd 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