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** ____/____/____ 2023-2024

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 _____	2.Parent/Guardian _____
Address _____	Address _____
Phone (cell, home, work) _____	Phone (cell, home, work) _____
Phone (cell, home, work) _____	Phone (cell, home, work) _____
Phone (cell, home, work) _____	Phone (cell, home, work) _____
Email _____	Email _____

NON-FAMILY/GUARDIAN EMERGENCY CONTACTS (please list two in order)

1.Name _____	2.Name _____
Relationship to child _____	Relationship to child _____
Phone (cell, home, work) _____	Phone (cell, home, work) _____
Phone (cell, home, work) _____	Phone (cell, home, 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 2 Signature Date