Emergency Contact and Medical Information

Last Name First Name

Date of Birth M F Sex

Parent's/Guardian's Name

Home Phone Work Phone

Cell Phone

Address

City, ST ZIP Code

Parent's/Guardian's Name

Home Phone Work Phone

Cell Phone

Address

City, ST ZIP Code

Alternative Emergency Contacts

Primary Emergency Contact

Home Phone Work Phone

Address

City, ST ZIP Code

Secondary Emergency Contact

Home Phone Work Phone

Address

City, ST ZIP Code

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature

Date

Please complete this form with information you are comfortable sharing.
Health conditions currently affecting your child are of the greatest significance.

Tetanus Shot? Yes ☐ No ☐ Date Administered _____

Allergies? Yes ☐ No ☐ To medications or seasonal/environmental? Please list _____
Has the allergy required emergency care in the past? Yes ☐ No ☐
Comments _____

Bee Sting Allergy? Yes ☐ No ☐ Describe reaction _____
Difficult breathing? Yes ☐ No ☐ Emergency medication? Yes ☐ No ☐

Food Allergy? Yes ☐ No ☐ Food _____ Describe reaction _____
Difficult breathing? Yes ☐ No ☐ Need emergency medication Yes ☐ No ☐
Comments _____

Asthma? Yes ☐ No ☐ Triggered by: _____ Treatment _____
Diagnosed by doctor: _____ Date _____

Diabetes? Yes ☐ No ☐ Date diagnosed _____ Type I ☐ Type II ☐
Takes insulin? Yes ☐ No ☐ Insulin Pump Yes ☐ No ☐
Insulin Injection Yes ☐ No ☐ Insulin Pen Yes ☐ No ☐

Epilepsy/Seizures ? Yes ☐ No ☐ Describe seizure _____
Date of last seizure _____ Medication _____
Is student currently under a doctor's care for seizures? Yes ☐ No ☐

Heart Condition ? Yes ☐ No ☐ Describe _____
Activity restrictions? _____ Medications? Yes ☐ No ☐

Skeletal Problem ? Yes ☐ No ☐ Describe _____
Activity restrictions? _____

Please check the following regarding health concerns that pertain to student:

Eyes: ☐ Glasses: ☐ reading ☐ distance ☐ contacts ☐ lazy eye ☐ crossed ☐ difficulty seeing

Ears: ☐ frequent infections ☐ tubes ☐ hearing difficulty
Hearing aid: ☐ right ☐ left

Other:

☐ ADD/ADHD	☐ anxiety	☐ bi-polar	☐ depression	☐ OCD	☐ ODD
☐ bladder	☐ bedwetting	☐ catheterization	☐ requires diapering	☐ bowel	☐ special diet
☐ blood-disorder	☐ blood pressure	☐ breathing	☐ dental	☐ eating	☐ headaches
☐ menstruation	☐ neurological	☐ nosebleeds	☐ phobias	☐ skin	☐ sleeping

Daily medication:
At home? Yes ☐ No ☐ At school? Yes ☐ No ☐ Emergency only? Yes ☐ No ☐
Name of medication _____ Reason for taking _____

List serious illness, injury, or syndrome _____
Surgeries (operations) _____
Condition that prevents or limits physical participation _____
Requires special health care? Explain _____

Other health information or concerns: _____