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 circle 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 Education (P.E.) participation _____
Requires special health care? Explain _____

Other health information or concerns: _____