EMERGENCY MEDICAL INFORMATION FORM

STUDENT INFORMATION

Student's Name ______________________________ **Birth Date** ____________________
(last) (first) (middle)
Student's Address ______________________________ **City** ____________ **Zip** ________
Student's Social Security Number ____________________ **Home Phone** ____________________
School Name ______________________________ **Phone** ____________________
Director ______________________________

PARENT INFORMATION

Mother's Name/Legal Guardian ____________________ **Home Phone** ____________________
Best time to contact ____________________ **Work Phone** ____________________

Father's Name/Legal Guardian ____________________ **Home Phone** ____________________
Best time to contact ____________________ **Work Phone** ____________________

If unable to contact parent/guardian, please contact:
Name ______________________________ **Relationship** ____________________
Home Phone ______________ **Work Phone** ______________ **Best time to contact** __________

HEALTH INFORMATION

Family physician ______________________________ **Office phone** ____________________
Office address ______________________________ **City** ____________ **Zip** ________
Insurance Company ______________________________ **Policy #** ____________________

Include a copy of your insurance card (front & back)

Student has a history of: *(check if applicable)*

_____ Diabetes _____ Asthma Attacks _____ Frequent Fainting
_____ Cardiac Condition _____ High Blood Pressure _____ Sleep Walking
_____ Epilepsy _____ Orthopedic Problems
_____ Other *(please explain)* ____
____

Student is allergic to: *(check if applicable)* _____ Gluten _____ Peanut
_____ Insect Stings _____ Milk Products _____ Egg Products
_____ Other *(please list)* ____

Student is allergic to the following medication(s): *(check if applicable)*
_____ Penicillin _____ Sulfa _____ Aspirin
_____ Tetracycline _____ Others *(please list)* ______________________

Date of last Tetanus shot: Month ______________ Year ______________
Student is presently taking the following prescribed medication:

____

I give permission to the physician or hospital to secure proper treatment and to order medication, injections, anethesia, or surgery for the child stated above.

______________________________ ____________________
Signature of Parent or Legal Guardian **Date**