Student Emergency /Medical Information

Last Name:____________________________ First Name:__________________________ DOB: ________

School:____ Room/Sec:_________ Grade:_______

Home Address: ____ Home phone: ____________

Mother: __________________________ email: ___________________________ phone: ____________

Father: __________________________ email: ___________________________ phone: ____________

Guardian: __________________________ email: ___________________________ phone: ____________

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone**

1.____

2.____

Childs Doctor/Clinic: ____ Phone:________________

Medical Insurance: MA___ CHIP____ Private_____

Insurance company name: _____________________________________ Policy Number________________

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	YES	NO
Ibuprofen (Advil, Motrin)	YES	NO

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _______________________________________

____

Other Health Problems: _______________________________

____

____

Does your child take medication? ____NO ____YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature ____ Date_______________