

**Emergency Medical Information**  
**Read and Complete Carefully**

In the event of any emergency and so that we may accurately handle all health care needs , we are asking that you complete this medical information/treatment form. Please be advised that should an emergency arise, you will be notified immediately.

Student's full name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

Parent/Guardian #1 \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

If the above cannot be reached, please notify:

\_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_

Primary insurance carrier for the student:

Company name: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Policy holder's name \_\_\_\_\_

I hereby give permission to the person in charge to allow hospital personnel and/or a licensed nurse or physician to perform emergency treatment if necessary.

Parent/Guardian signature: \_\_\_\_\_ Date \_\_\_\_\_

I hereby give permission to the person in charge to transport my child to or from a doctor and/or hospital for emergency treatment.

Parent/Guardian signature: \_\_\_\_\_ Date \_\_\_\_\_

***Please complete both sides.***

**General Information**

1. Are there any physical activities in which your child should NOT participate?  
Yes \_\_\_\_ No \_\_\_\_ If yes, please give details (this information is confidential).

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2. Are there any conditions which may warrant special consideration, such as diet needs or restrictions, emotional problems, sleepwalking, etc.?  
Yes \_\_\_\_ No \_\_\_\_ If yes, please give details (this information is confidential).

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**Medical Information**

Child's allergies, if any (medications, insects, foods, etc.)

Describe reaction \_\_\_\_\_

May your child be administered Tylenol or Advil if necessary? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child currently taking medication? Please check below.

- 1. Prescription medication
- 2. Non-prescription medication
- 3. No medication

IF YOU CHECKED 1 OR 2 ABOVE, PLEASE COMPLETE BELOW:

Name of medication(s) and dosage \_\_\_\_\_

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Reason for taking medication(s) \_\_\_\_\_

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Time(s) medication(s) is to be administered \_\_\_\_\_

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**IMPORTANT: Both prescription and non-prescription medications sent for the child must be labeled with the child's full name and instructions for administration of the medication. All medications, both prescription and non-prescription, must be in the original container. Prescription drugs must have a legible pharmacy label. A note from the parent granting permission to administer medication to the child must accompany all medication. All medication and notes must be given to the nurse in charge upon the morning of departure.**