MEDICAL/EMERGENCY CONTACT INFORMATION

For the Student's Medical File

Name of Student:_____ **Grade:** _____

Student's Birthdate: _____ **2017/2018**

MEDICAL/ PHYSICAL INFORMATION

Present Physical Conditions

Does your child take medication? ☐ **Yes** ☐ **No**

If yes, please list _____

Does your child have any allergies (medication, food, etc.)? ☐ **Yes** ☐ **No**

If yes, please list _____

Present illnesses or physical handicaps: _____

Hearing Problems: _____

Visual Problems: _____

☐ Child does not wear glasses ☐ Child wears glasses:

☐ Child wears contact lenses ☐ *for distance* ☐ *for reading* ☐ *at all times*

☐ Child is receiving eye therapy

EMERGENCY INFORMATION

Home Phone:_____ **Home Address:** _____

Dad _____ **Mom** _____

Work Phone _____ **Work Phone**_____

Cell _____ **Cell** _____

Persons to be contacted when parents can not be reached:

Name_____ **Name** _____

Relationship_____ **Relationship** _____

Phone _____ **Phone**_____

Family Doctor _____ **Family Doctor Phone**_____

In the event that my child sustains injury requiring medical treatment, I authorize the school district and its employees to administer and/or to arrange for such treatment by medical personnel as needed for the health and welfare of my child (including transport of the student to a hospital or medical center if appropriate), and further authorize such medical personnel to administer such treatment. I will accept financial responsibility for any expense incurred. I further agree to hold harmless and release the school district and its employees from all claims resulting from and or arising out of the provision to my child of emergency medical treatment by school or medical personnel. THIS AUTHORIZATION IS TO CONTINUE FROM YEAR TO YEAR UNLESS REVOKED IN WRITING.

√Parent's Signature:_____**Date:** _____