

# MEDICAL/EMERGENCY CONTACT INFORMATION

For the Student's Medical File

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Birthdate: \_\_\_\_\_

2010/2011



## MEDICAL/ PHYSICAL INFORMATION

### Present Physical Conditions

Present allergies: \_\_\_\_\_

Is child on medication?  Yes  No

If yes please list \_\_\_\_\_

Is child allergic to any medication?  Yes  No

Please explain \_\_\_\_\_

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 or Pager \_\_\_\_\_

Cell or Pager \_\_\_\_\_

*\*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: \_\_\_\_\_