Student Name: ________________________________

EMERGENCY MEDICAL INFORMATION AND TREATMENT
(PLEASE PRINT)

Does your child have any allergies to Medications? YES NO (circle one)

If yes, list and describe symptoms: ____

____

Does your child have any food allergies? YES NO (circle one)

If yes, list and describe symptoms: ____

____

Does your child take any medications? YES NO (circle one)

If yes, list and describe symptoms: ____

____

All medications must be kept with and administered by the school Health Coordinator/Nurse with a parental note or written doctor's orders. No child will be allowed to carry or administer his/her own medication. **A copy of a physical exam in the past year must be kept on record at the school health office.**

Doctor: ____________________________________ Phone: ____________________

Address: ____

Preferred Hospital: ____

Is your child covered by medical insurance? YES NO (circle one)

If yes, please list insurance carrier: ______________________ Policy #:____________________

I give my permission for the school nurse to share this information with my child's teacher. I give my permission for the school nurse to discuss this information with my child's doctor.

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Signature of Parent/Guardian