

MEDICAL/EMERGENCY CONTACT INFORMATION

For the Student's Medical File

Name of Student: _____ Grade: _____

Student's Birthdate: _____

2018/2019



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: _____