



## Emergency Contact and Medical Information

In case of an emergency, it is imperative that the School be able to reach the student's parent or guardian. Please complete every section of the form carefully and accurately.

Student's full name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_  
(Last) (First) (Middle) dd/mm/yyyy

Residential address \_\_\_\_\_  
\_\_\_\_\_

Student Resides with the following:      Father      Mother      Boarding      Other (Please give details)

### Primary Parent/Guardian Contact

Name \_\_\_\_\_ Residential phone number \_\_\_\_\_ Mobile phone number \_\_\_\_\_  
Business phone number \_\_\_\_\_

### Secondary Parent/Guardian Contact

Name \_\_\_\_\_ Residential phone number \_\_\_\_\_ Mobile phone number \_\_\_\_\_  
Business phone number \_\_\_\_\_

**IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED, PLEASE LIST NAME AND PHONE NUMBER OF RELATIVE OR FRIEND WE MAY CONTACT.**

**Primary Contact Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
Residential phone number \_\_\_\_\_ Mobile phone number \_\_\_\_\_ Business phone number \_\_\_\_\_

**Secondary Contact Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
Residential phone number \_\_\_\_\_ Mobile phone number \_\_\_\_\_ Business phone number \_\_\_\_\_

Physician \_\_\_\_\_ Phone No. \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone No. \_\_\_\_\_

## Medical Information and Consent



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

**Medication:**

Does the student require medication? Yes No If yes, list the name of medications and frequency

Does the student take any medications during school hours? Yes No If yes, list the name of medications and frequency

If your student requires medication at school, all medication sent to school must be in the original prescription container with a current date and the student's name.

**No Over the Counter medication can be administered to your student without parent permission.**

**Vision and/or Hearing Problems:**

Wears glasses/contacts: for board work for reading all the time No

Date of last eye exam \_\_\_\_\_ Wears hearing aid(s)? Yes No

**Medical Conditions:** Does student have any of the following:

Heart condition  Diabetes  Asthma  Seizure Disorder  ADD/ADHD  Migraines  Depression

Other (specify) \_\_\_\_\_

Asthma (if checked) uses inhaler on daily medication Seizures (if checked) On medication? Yes No Diabetes (If checked) Insulin dependent? Yes No

Severe allergies requiring medication? Please give details: \_\_\_\_\_

Food/Environmental  Stinging Insects/Bees  Medicines/Drugs  Other

If checked, please give details: \_\_\_\_\_

Does the student have any limits on physical activity? Yes No If yes, please give details \_\_\_\_\_

**EMERGENCY TREATMENT AUTHORIZATION**

*I/we, the undersigned parent(s) or legal guardian of \_\_\_\_\_, a minor, do hereby give authorization and consent to the School to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached. I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the School. I certify that all information on this card is complete and correct.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_