

Student Emergency /Medical Information

Last Name: _____ First Name: _____ DOB: _____
 School: _____ Room/Sec: _____ Grade: _____

Home Address: _____ Home phone: _____
 Mother: _____ email: _____ phone: _____
 Father: _____ email: _____ phone: _____
 Guardian: _____ email: _____ phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child	Phone
1. _____	_____
2. _____	_____

Childs Doctor/Clinic: _____ Phone: _____
Medical Insurance: MA ___ CHIP ___ Private ___
 Insurance company name: _____ Policy Number _____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	YES	NO
Ibuprofen (Advil, Motrin)	YES	NO

Please CIRCLE the following if your child:

Wears: Glasses Hearing aid
 Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

Other Health Problems: _____

Does your child take medication? ___ NO ___ YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature _____ Date _____