

Emergency Contact and Medical Information

Child's Name	Date of Birth		M	F
			Sex	
Parent's/Guardian's Name	Parent's/Guardian's Name			
()	()	()	()	
Home Phone	Work Phone	Home Phone	Work Phone	
Address		Address		
City, ST ZIP Code		City, ST ZIP Code		

Alternative Emergency Contacts

Primary Emergency Contact		Secondary Emergency Contact		
()	()	()	()	
Home Phone	Work Phone	Home Phone	Work Phone	
Address		Address		
City, ST ZIP Code		City, ST ZIP Code		

Medical Information

Hospital/Clinic Preference

Physician's Name	Phone Number
Insurance Company	Policy Number

Allergies/Special Health Considerations

By signing below, I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

When medication absolutely must be taken by an elementary school child during the school day, parents (guardians) shall provide explicit written instructions, including instructions as necessary from their physician or other medical practitioner regarding the need for medication or specific medical care.

By signing below, I also give permission for non-medically trained school personnel to oversee such self-administration of medication, if applicable, and to provide other routine medical care as necessary during the school day.

Parent's/Guardian's Signature	Date
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Immunizations

- Please **check** the appropriate line.
- My child(ren) receives regularly scheduled immunizations. _____
 - My child(ren) does **NOT** receive a regular schedule of immunizations. _____ Please attach a letter stating the reason.

Parent's/Guardian's Signature	Date
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