

Student Emergency /Medical Information

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

<p>Please circle below to give permission to the school nurse to give your child medication.</p>	<p>Please CIRCLE the following if your child:</p> <p>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: _____ _____ —</p>
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Does your child take medication? ___NO ___YES (please list)

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 _____