

Student Emergency Care Form

Student's Last Name First MI DOB Age Grade

Sex: M or F

Fathers' Name: _____ Mother's Name: _____

Address _____ Address _____

Phone: HM _____ WK _____ Phone: HM _____ WK _____

Name of Business: _____ Name of Business: _____

Cell _____ Cell _____

Other Emergency Contacts:

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Primary Care Physician _____ Phone _____

Choice of Hospital _____ Is child covered by Ins. _____

List allergies or other medical information: _____

In case of an emergency, if none of the above mentioned contacts can be reached, I give permission to Dr. _____ to be wholly responsible for the care of my child. I will be responsible for the payment of all expenses incurred.

My child has permission to receive medications (circled from the list) below, as administered within reason by the school nurse.

- | | |
|--------------|-------------|
| Tylenol | Cough Drops |
| Ibuprofen | Neosporin |
| Pepto-Bismol | Caladryl |
| Maalox | Carmex |
| Anbesol | Burn-Gel |

Parent or Guardian Signature

Date