Student Emergency / Medical Information

First Name: ____________ Last Name: ____________ DOB: ____________

School: Immaculate Conception Academy School Year/Grade: ____________

Home Address: ____________ Home Phone: ____________

Mother: ____________ Email: ____________ Cell Phone: ____________

Father: ____________ Email: ____________ Cell Phone: ____________

Guardian: ____________ Email: ____________ Cell Phone: ____________

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

Name and Relationship to child **Phone Number:**

1) ____________

2) ____________

Dentist: ____________ Phone: ____________

Child's Doctor: ____________ Phone: ____________

Medical Insurance: CHIP ______ Private: ____________

Insurance Company Name: ____________ Policy #: ____________

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

Acetaminophen (Tylenol)	Yes	No
Ibuprofen	Yes	No
Topical Hydrocortone	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? Yes (please list) ______ No ______

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for School Authorities to administer medications you indicate on this emergency form, during school hours, on field trips, and after school activities. I authorize the school 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: ____________