HEALTH CLINIC
EMERGENCY CONTACT & PROCEDURE CARD

Student's Name _____ Gender: M_____ F_____ D.O.B._____ Grade_____
Last First Middle

Address _____
Home Telephone _____ Beeper/Cell Phone _____
Name of Father/Guardian _____ Home Phone _____
Employer _____ Work Phone _____
Name of Mother/Guardian _____ Home Phone _____
Employer _____ Work Phone _____
Student lives with: (Circle One) both parents mother father shared custody guardian
Call first _____ Call second _____

IN CASE OF EMERGENCY AND **PARENTS CAN'T BE REACHED**, CONTACT THE FOLLOWING (List 2)

Name _____ Name _____
Relationship _____ Relationship _____
Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____
Doctor _____ Phone _____
I give the school nurse permission to obtain physical exam and immunization information for school record purposes.

_____ _____
Signature Date
Medical Problems and/or restrictions _____

*PLEASE NOTIFY THE SCHOOL OF ANY CHANGES THROUGHOUT THE SCHOOL YEAR
Did student have any serious illness requiring surgery, hospitalization or treatment? Yes ____ No ____
If yes, please explain _____
List any allergies: _____
List medications taken at home or school: _____
Does your child have health insurance: Yes _____ Insurance Company _____ No ____
Has there been any change in home or family that may affect your child's work at school? Yes ____ No ____
If yes, please explain _____
Please note any restrictions on calling or pick up of your child if ill or injured and/or any legal custody concerns that the school should be aware of:

_____

I give my permission for this information to be shared with school staff as necessary. I hereby authorize the school to obtain medical care in case for emergency including transportation by ambulance to a medical facility. I hereby authorize the school to allow my child to be picked up by the listed individuals if I cannot be reached. I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

Please mark (X) approval of each medication

Dose will be given according to age/weight as per product instruction

Medication	Symptoms	**Approve Use (X) or write in "no"**
Acetaminophen (Tylenol)	...for minor pains, complaints, and headaches	
Ibuprofen (Motrin)	...for minor pains, complaints and headaches	
Anti-acid (Tums)	...for minor stomach complaints	
Cough Drops	...for minor coughs and sore throats	
Antibiotic Ointment	...for minor scrapes and abrasions	
Hydrocortisone Cream	...for minor skin rashes, itching	
Diphenhydramine (Benedryl)	...for minor allergic reactions	

I (we), the parent(s) or guardian(s), authorize the school to assist our child in taking the above medications and agree that we will not hold liable any member of the school staff or individual of official capacity who is directed by us (the parents/guardian) and the school administration to assist our child in taking said medications.

Date: _____ Signature/Guardian _____