

Medical/Contact Information

Student _____ DOB _____
Last Name First Name MI

Health History (Answer Yes or No) Additional Information may be listed on back of form.

Allergies (List Allergies) _____

Physical Handicaps (Specify) _____

Asthma _____ Diabetes _____

Seizures _____ Sickle Cell _____

Cancer _____ Auto Immune Disorder _____

Vision _____ Hearing _____

Other mental or physical health issues which may be a concern at school: _____

(Specify) _____

Does your child have any condition that would limit physical education activities? _____

(Specify) _____

Does your child take any prescribed or over the counter medication routinely? _____

(List) _____

Please list any additional information on the back

EMERGENCY CONTACT INFORMATION

Parent/Guardian Name: _____ Home Phone _____

Cell Phone _____ Work Phone _____

Parent/Guardian Name: _____ Home Phone _____

Cell Phone _____ Work Phone _____

If parents are divorced or separated, who has physical custody?

Joint _____ Mother _____ Father _____ Guardian _____

*Parents should notify school immediately if there is a change. Additional numbers can be added on back.

If parents cannot be reached, list two nearby persons who will assume care of your child.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Child's Healthcare Provider _____ Phone _____

**If your child has any chronic health condition (asthma, diabetes, seizures, etc.), you MUST provide an Action Plan signed by the child's doctor at the start of each school year. Forms are available at every school and online.

I understand that medications of any kind are not allowed on school grounds without the proper medical authorization on file and must be brought to the school by the parent/adult unless other arrangements have been mad with the school nurse. Authorization forms are available at every school and online.

I understand that for the safety of my child, or to provide for the educational program, the school nurse may need to share information about my child's health condition with appropriate school staff. This will be done in a confidential manner. If you do not wish for that information to be shared, I must request this in writing and file it with the school nurse.

School clinic personnel or designated staff has my permission to contact my child's physician for further medical information. In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate evaluation and/or transport to the nearest appropriate facility. I, the parent/legal guardian authorize this transport and treatment by the EMS and hospital emergency staff for my child. _____ (student name)

Parent/Guardian Signature

Date

Please update information as it changes during the year.

The Meriwether County School District does not discriminate on the basis of race, color, religion, national origin, age, disability, or sex in its employment practices, student programs and dealings with the public. It is the policy of the Board of Education to comply fully with the requirements of Title VI, Title IX, Section 504 of the Rehabilitation Act of 1973, the Americans With Disabilities Act and all accompanying regulations.