The Marshall School

Emergency Contact & Medical Information Form

This form is to be completed annually by a parent/guardian ONLY.
Please notify the school of any changes in this information throughout the school year.

STUDENT INFORMATION Today's Date_____

Last Name_____ First Name_____ Middle Initial_____ Age___

Preferred Name _____Gender_____ Height_____ Weight_____

Eye Color_____Hair Color_____Date of Birth_____ /_____ /_____

Residence Address_____

Identifiable Physical Characteristics (birthmarks, scars, etc.)_____

PARENT / GUARDIAN INFORMATION - *Use the numerals 1-6 to indicate the order in which you wish to be contacted. Emergency contacts will only be called if we cannot contact parents/guardians first.*

Mother/Guardian_____ Employer_____

Address (*if different*)_____

Work Phone _____ [ ] Cell Phone _____ [ ] Email _____ [ ]

Father/Guardian _____ Employer _____

Address (*if different*) _____

Work Phone _____ [ ] Cell Phone _____ [ ] Email _____ [ ]

PICK-UP / EMERGENCY CONTACT INFORMATION – *if parents cannot be contacted*

(1) Name _____Relationship to Child _____ Phone Number _____

Address _____

(2) Name _____Relationship to Child _____ Phone Number _____

Address _____

(3) Name _____Relationship to Child _____ Phone Number _____

Address _____

EMERGENCY MEDICAL TREATMENT

Preferred Hospital_____Telephone_____

Insurance Carrier_____Policy Number_____

Policy Holder_____ Policy Holder DOB ____ /_____ /_____

Primary Care Provider_____ Telephone_____

Practice Name_____ Fax_____

Address_____

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ALLERGY INFORMATION

List any ***food allergies*** with type and severity of reaction _____

_____

List any ***food intolerances*** _____

_____

List any ***environmental allergies*** with type and severity of reaction_____

_____

List any ***medication allergies*** with type and severity of reaction_____

DIAGNOSED MEDICAL CONDITION(S) – *please check all that apply*

- ☐ Asthma
- ☐ Diabetes (Type____)
- ☐ Hypoglycemia
- ☐ Seizure Disorder
- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Sensory Processing Disorder
- ☐ Auditory Processing Disorder
- ☐ Other Condition(s)

_____

_____

_____

DAILY MEDICATIONS(s) – *anything taken routinely, to include vitamins and OTC medications*

Medication_____ Dose_____ Frequency_____ Needed at School (Yes / No)

Medication_____ Dose_____ Frequency_____ Needed at School (Yes / No)

Medication_____ Dose_____ Frequency_____ Needed at School (Yes / No)

Medication_____ Dose_____ Frequency_____ Needed at School (Yes / No)

Medication_____ Dose_____ Frequency_____ Needed at School (Yes / No)

MEDICATIONS REQUIRED AT SCHOOL – *requires a plan signed by licensed medical provider for all listed below*

- ☐ Epinephrine *(Allergy & Anaphylaxis Emergency Plan required)*
- ☐ Albuterol *(Asthma Action Plan required)*
- ☐ Other Medication (*Medication Authorization Form required*) _____
- ☐ Insulin *(Diabetes Medical Management Plan required)*
- ☐ Seizures Meds *(Seizure Action Plan required)*

In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment. I authorize any hospital and licensed medical provider to provide all reasonably necessary treatment immediate emergency aid as required at the time for my child's health and safety. I recognized that I am responsible for all charges related to transportation and medical treatment.

Parent/Guardian Name (*Please Print*)_____ Date_____

Parent Signature_____