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.

Last Name First 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 (f different) [] Cell Phone [] Email [] Father/Guardian Employer Address (f different) [] Cell Phone [] Email [] Phone Number Address (f different) [] Relationship to Child Phone Number Address [] Name Relationship to Child Phone Number Address [] Phone Number Address [] Phone Number Address [] Phone Number Phone Number Address [] Phone Number [] Phone Number [] Preferred Hospital [] Telephone [] Phone Number [] Preferred Hospital [] Telephone [] Phone Number [STUDENT INFORMA	<u>ATION</u>	Today's Date				
Eye Color	Last Name	First Name		Middle Initia	lAge		
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	Preferred Name		Gender	Height	Weight		
PARENT / GUARDIAN INFORMATION - Use the numerals 1-6 to indicate the order in which you wish to be contacted.	Eye Color	Hair Color	Date of Birth_	/	/		
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	Residence Address						
Emergency contacts will only be called if we cannot contact parents/guardians first. Mother/Guardian	Identifiable Physica	l Characteristics (birthmarks, scars, etc.)					
Mother/GuardianEmployer	PARENT / GUARDIA	AN INFORMATION - Use the numerals 1-6 t	to indicate the order in wi	nich you wish to	b be contacted.		
Address (if different) Work Phone [] Cell Phone [] Email [] Father/Guardian Employer	Emergency contact	s will only be called if we cannot contact pa	arents/guardians first.	•			
Work Phone [] Cell Phone [] Email [] Father/Guardian Employer	Mother/Guardian_		Employer				
Father/Guardian Employer	Address (<i>if differen</i>	t)					
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	Work Phone	[] Cell Phone	[] Email		[]		
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 (3) Name Relationship to Child Phone Number Address	Father/Guardian _		Employer				
PICK-UP / EMERGENCY CONTACT INFORMATION — if parents cannot be contacted (1) Name	Address (if differen	t)					
Relationship to Child	Work Phone	[] Cell Phone	[] Email		[]		
Address	PICK-UP / EMERGE	NCY CONTACT INFORMATION – if parents	cannot be contacted				
Relationship to Child	(1) Name	Relationship t	to Child	Phone Numb	oer		
Address	Address						
Relationship to Child Phone Number Address Phone Number	(2) Name	Relationship t	to Child	Phone Numb	oer		
Relationship to Child Phone Number Address Phone Number	Address						
Preferred Hospital				Phone Numb	oer		
Preferred Hospital	Address						
Insurance CarrierPolicy Number Policy HolderPolicy Holder DOB// Primary Care ProviderTelephone Practice NameFax	EMERGENCY MEDI	CAL TREATMENT					
Policy Holder Policy Holder DOB / / Primary Care Provider Telephone Practice Name Fax	Preferred Hospital_		Telephone				
Policy Holder Policy Holder DOB / / Primary Care Provider Telephone Practice Name Fax	Insurance Carrier						
Practice NameFax							
	Primary Care Provid	der					
Address	Practice Name		Fax				
	Address						

The Marshall School

ALLERGY INFORMATION					
List any <i>food allergies</i> with type and severity	of reaction				
List any <i>food intolerances</i>					
List diffy food interestances					
List any <i>environmental allergies</i> with type ar	nd severity of re	eaction			
List any <i>medication allergies</i> with type and se	everity of react	tion		<u></u>	
DIAGNOSED MEDICAL CONDITION(S) – pleas	se check all that	t apply			
□ Asthma □	Autism Spectrum Disorder Other Condition(s)				
□ Diabetes (Type) □	Sensory Processing Disorder				
☐ Hypoglycemia ☐	Auditory Processing Disorder				
□ Seizure Disorder			_		
□ ADHD			_		
DAILY MEDICATIONS(s) – anything taken rou	tinely, to includ	de vitamins and OTC n	nedication	s	
Medication	Dose	Frequency	Ne	eeded at School (Yes / No)	
Medication	Dose	Frequency	Ne	eeded at School (Yes / No)	
Medication	Dose	Frequency	Ne	eeded at School (Yes / No)	
Medication	Dose	Frequency	Ne	eeded at School (Yes / No)	
Medication	Dose	Frequency	Ne	eeded at School (Yes / No)	
MEDICATIONS REQUIRED AT SCHOOL - requ	_	-	-		
☐ Epinephrine (Allergy & Anaphylaxis Emergency Plan		•			
required)		required)	. (6. 1	A 5/	
□ Albuterol (Asthma Action Plan required)	<i></i>	☐ Seizures Med	is (Seizure	Action Plan required)	
Other Medication (Medication Authorization required)					
In case of emergency, my child may be transparted treatment. I authorize any hospital and licens immediate emergency aid as required at the all charges related to transportation and mediate	sed medical pro time for my ch	ovider to provide all re ild's health and safety	asonably	necessary treatment	
Parent/Guardian Name (Please Print)		Da	ate		
Parent Signature					