The Marshall School

Emergency Contact & Medical Information Form

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

STUDENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth____/____/_____ Preferred Name _____

Residence Address _____

Age _____ Gender _____ Height _____ Weight _____ Eye Color _____ Hair Color _____

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

(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_____

Address _____ Fax _____

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MEDICAL 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)

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

Daily Medication(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)

Medication Required at School - *require plans 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_____