The Marshall School

Medical & Emergency Information

Today's Date______________________________

STUDENT INFORMATION

Student's Full Name____ Date of Birth_______________________

Home Address____

City, State, Zip____

Height ________________ Weight ________________ Eye Color ________________ Hair Color _______________

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

____

PHONE NUMBERS *(Please use the numerals 1-6 to indicate the order in which you wish to be contacted.)*

Mother's Home_____________________[______] Father's Home______________________[______]

Mother's Cell_______________________[______] Father's Cell________________________[______]

Mother's Work_____________________[______] Father's Work______________________[______]

MOTHER'S NAME____

Address, if different from student's____

Employer____

Email____

FATHER'S NAME____

Address, if different from student's____

Employer____

Email____

EMERGENCY MEDICAL TREATMENT

Preferred Hospital____Telephone_________________________________

Address___________________________________City_________________________State_________Zip___________

Insurance Carrier____Policy Number_____________________________

Student's Physician_______________________________________Telephone_________________________________

Address___________________________________City_________________________State_________Zip___________

The Marshall School

HEALTH, ALLERGY, & MENU INFORMATION

List any *food allergies* your child currently has. Be specific as possible.____________________________________

____

List any *dietary/menu restrictions or food intolerances* that your child has (i.e., vegetarian, dairy intolerance, soy milk only, etc.)____

List any medication allergies or environmental allergies your child currently has. Be specific as possible.________

____

Please specify any chronic problems such as asthma, ADHD, diabetes, epilepsy. ____________________________

____

[ ] Requires Epinephrine *(a Food Allergy Plan is required)*

[ ] Has seizures *(a Seizure Action Plan is required)*

[ ] Requires Albuterol *(an Asthma Allergy Plan is required)*

[ ] Requires Insulin *(a Medical Management Plan is required)*

EMERGENCY CONTACT INFORMATION

Contact #1 Name____Relationship to Child________________________

Address____

City____State______________________Zip__________________

Phone____Alternate Phone___________________________

Emergency Contact? [ ] Yes [ ] No Authorized to Pick Up? [ ] Yes [ ] No

Contact #2 Name____Relationship to Child________________________

Address____

City____State______________________Zip__________________

Phone____Alternate Phone___________________________

Emergency Contact? [ ] Yes [ ] No Authorized to Pick Up? [ ] Yes [ ] No

Subject to efforts to contact the parent(s), guardian(s), or individuals designated on this car, I authorize any hospital or doctor to provide immediate emergency aid as might be required at the time for my child's health and safety. I authorize all reasonably necessary treatment, including, but not limited to, first aid, x-rays, anesthetics, surgery, and/or hospitalization. I understand that I will accept responsibility for all expenses of this service that are not covered by insurance.

Parent Name (Please Print)____Date________________________

Parent Signature____