School Year: 2020-2021

MEDICAL EMERGENCY FORM

In case of an emergency, when we cannot be contacted, my child,

_____ may receive medical treatment from

_____ (physician) and/or

_____ (hospital).

We will be responsible for any charges related to the emergency medical treatment.

July 7, 2020
Date

_____
Parent or Legal Guardian Signature

Hospitalization Coverage:

Company: _____

Policy Number: _____

Student Medical Information

Note: The MEDICATION PERMISSION FORM must be completed if you wish for your child's teacher to administer any medication during school hours.

1. Chronic medical conditions (asthma, seizures, diabetes, etc.) ◯ YES ◯ NO

   Describe: _____

2. Food allergies ◯ YES ◯ NO

   Describe: _____

3. Other allergies ◯ YES ◯ NO

   Describe: _____

Please complete the attached EMERGENCY PLAN as needed

Audiology Information

Is your child is under the care of an audiologist? ◯ YES ◯ NO

Audiologist's name: _____

Place of Employment: _____

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Emergency Plan

Name: Date: July 7, 2020

- ○ No Emergency Plan is Needed
- ○ Emergency Plan Completed Below

Reason for Plan:

Reaction to look for:

Emergency Action:

Medication:

Location of Medication:

Parent signature | Teacher signature | date