

# EMERGENCY MEDICAL FORM 2011-2012

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

## Parent 1

## Parent 2

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work: \_\_\_\_\_

Work: \_\_\_\_\_

Cell (area code): \_\_\_\_\_

Cell (area code): \_\_\_\_\_

E-Mail: \_\_\_\_\_

E-Mail: \_\_\_\_\_

FAX: \_\_\_\_\_

FAX: \_\_\_\_\_

In case of an emergency and a parent cannot be reached, call:

\*\*Name: \_\_\_\_\_

Phone: \_\_\_\_\_

\*\*Name: \_\_\_\_\_

Phone: \_\_\_\_\_

**\*\*Please notify the above people of their responsibilities in this matter.\*\***

Name, address and telephone number (area code) of family physician:

\_\_\_\_\_  
\_\_\_\_\_

Name of Medical Ins. Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Allergies:  LIFE THREATENING  Medication: \_\_\_\_\_  Insect: \_\_\_\_\_

Seasonal \_\_\_\_\_  Food\* \_\_\_\_\_  Other \_\_\_\_\_

\*Please specify if Food Intolerance or Food Allergy: \_\_\_\_\_

-----OVER PLEASE-----

Date of last tetanus vaccination: \_\_\_\_\_

Has your child, during the past year, had any illness, injury or operation? Please Specify (with dates) \_\_\_\_\_

Does your child take any medications on a regular basis (excluding vitamins)?\* \_\_\_\_\_

Will your child need to carry this medication or medical apparatus on field trips? \_\_\_\_\_

If yes, what is it and who is expected to administer this medication? (Must provide DDS with OTC/Rx auth form) \_\_\_\_\_

Do you have any other information or recommendations that would aid us in understanding your child's need(s)? (i.e. hearing loss, eyeglasses - this information may be put on a confidential Health Alert List that is given to the Faculty/Staff) \_\_\_\_\_

**\*No medication may be given in the school without a written order from a physician and parental consent. All medication must be in the original bottle with the physician's prescription. Students may not carry any medication to school; an adult must deliver it to the office.**

I hereby empower a faculty representative of Dutchess Day School to act on my behalf in an emergency situation if I cannot be reached. If necessary, I authorize the above information to be given to DDS faculty and my contact names.

**PARENT SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

In the event of an early dismissal, please:  
\_\_\_\_\_ send my child home on the bus without calling.  
\_\_\_\_\_ send my child home with \_\_\_\_\_ if I cannot be contacted.  
\_\_\_\_\_ keep my child at school until I am contacted.  
\_\_\_\_\_ other \_\_\_\_\_

**Please complete a separate form for each child in the family.  
Please sign before returning to the office**

**Revised 04/11**