EMERGENCY CARE INFORMATION

In the case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian or a designated emergency contact.
2018-2019

STUDENT INFORMATION

Last: First: Middle:	Date of Birth:	Gender: ☐ M ☐ F	Grade:
	Bus # (AM)	Bus # (PM)	
☐ Student has medical alert information on file.			

PARENT/GUARDIAN CONTACT INFORMATION

This form is to be completed by the resident parent/guardian. The resident parent/guardian is the natural or adoptive parent or legal guardian with whom the student resides for a full calendar year.

Enrolling Parent/Guardian Last: First: Middle:		Telephone Home:
Street Address: (If providing PO Box, must also provide street address). Apt. #		Work:
		Cell:
City: State: Zip:		Language
Employer:		
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Resides With ☐ Yes	Email:
		Are you a current military family? ☐ Yes ☐ No ☐ Refuse to Answer

Other Parent/Guardian Residing at Above Address Last: First: Middle:		Telephone Home:
Street Address: (If providing PO Box, must also provide street address). Apt. #		Work:
		Cell:
City: State: Zip:		Language
Employer:		
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Email:	

Other Parent/Guardian Last: First: Middle:		Telephone Home:
Street Address: (If providing PO Box, must also provide street address). Apt. #		Work:
		Cell:
City: State: Zip:		Language
Employer:		
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Should contact receive mailings throughout the school year: ☐ Yes ☐ No	
	Email:	

Other Parent/Guardian Last: First: Middle:		Telephone Home:
Street Address: (If providing PO Box, must also provide street address). Apt. #		Work:
		Cell:
City: State: Zip:		Language
Employer:		
Relationship: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent ☐ Other _____	Should contact receive mailings throughout the school year: ☐ Yes ☐ No	
	Email:	

OTHER CONTACT INFORMATION

Please list at least two people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. By listing these individuals you are granting permission to pick your student up from school during the school day.

Name of Person	Relationship	Language	Telephone

Complete reverse side.

MEDICAL HISTORY (Your child's medical condition will be shared with necessary school personnel unless otherwise indicated). Please check any medical condition that pertains to your child and provide an explanation.

Condition	Yes	Comments	Condition	Yes	Comments
ADD/ADHD			Cardiovascular		
Allergy:			Diabetes		
Bee Sting			Gastrointestinal		
Drug		*Comment Required:*	Hearing Disorder/Deafness		
Food		*Comment Required:*	Migraines		
Latex			Orthopedic Disorder		
Peanut			Seizure Disorder		
Seasonal			Vision Disorder		
Tree Nut			Other		
Asthma			Other		

Additional Information:

Physician's Name	Telephone

MEDICATIONS TAKEN AT HOME:
Please list the name and reason for any medication, *prescribed or over-the-counter*, that your child is receiving on a regular basis.

Name	Reason	Dose	Times

OVER-THE-COUNTER-MEDICATIONS AVAILABLE AT SCHOOL/CAMP per School Physician Order: Please note that any medication/s *NOT* on this list will require a physician's order to be given at school/camp.

My child may **NOT** be given any medications while at school: _____
My child may be given (please initial medications you authorize):

Medication	Initial	Dose
Acetaminophen *(Tylenol)*	_____	_____
Ibuprofen *(Advil)*	_____	_____
Antacid *(Tums)*	_____	_____
Benadryl *(Allergy Symptoms)*	_____	_____

If you do not indicate a dose, it will be administered according to the student's age/weight.

Parent/Guardians release the Fairfield Area School District, its officers, agents, and employees from all claims and liabilities of any kind arising out of the dispensing of medication to the student pursuant to the authorization granted herein.

In the event of an emergency which would require medical care and treatment to be administered to the student, I/we hereby authorize any physician, hospital, or other health care provider to give emergency medical care and treatment to this student.

The undersigned have read this Medical Authorization Consent Form and declare and affirm that I/we agree to the consents herein stated.

_____

Parent/Guardian – Please Print Signature Date

_____

Parent/Guardian – Please Print Signature Date

_____

Student's Signature (only if student is 18 or older) Date