2022-23 Medical Emergency/Information Form

This form will be taken to all field trips and will be used in case of an emergency.

MEDICAL INFORMATION

Grade Level: _____

Name of Minor: _____ Birthdate: ____/____/____ Relationship to you: _____

Medication Allergies: _____

_____

Specific medical allergies to food and/or insect, chronic illnesses, or other conditions: _____

_____

_____

_____

_____

Does your child wear glasses/contacts? Yes_____ No_____

How often? _____ constant _____ just for reading _____ to see board

Does your child have an Epi-Pen? Yes_____ No_____

Does your child have Asthma? Yes_____ No_____

Does your child have Diabetes? Yes_____ No_____

Does your child have a Seizure Disorder? Yes_____ No_____

Does your child have ADD/ADHD? Yes_____ No_____

Please list any medications (prescription or non-prescription) that your child takes regularly: *(Please include inhalers/nebulizers)*

_____

Please list any other health conditions that you feel could impact your child while at school:

_____

Family Physician _____ Phone: _____

CONTACT IN CASE OF AN EMERGENCY

Name _____ Phone: _____

Address _____

If you wish to be notified of the schedule for pesticide/insecticide registry spraying, please check here: _____

Medical Insurance Company _____

Group or Policy Number _____

Your school district is a "Health Care Service Provider" with the Illinois Department of Public Aid/Medicaid. Per this providership the school district will receive federal funds for health care services provided to a student with a Medicaid health care coverage. If your child has "Medicaid coverage" please complete the following:

Name as listed on your "Medi-Plan Card" _____

Nine digit "Recipient Number" ___ ___ ___ ___ ___ ___ ___ ___ ___

As a parent or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above named minor in the event of a medical emergency, which, in the opinion of the attending physician, may endanger his life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

_____ _____

Parent/Legal Guardian Signature **Date**