

STUDENT MEDICAL EMERGENCY INFORMATION

Student's Name: _____ Grade & HR Teacher: _____

Date of Birth: _____ Primary Email: _____

Please indicate the order of preference you wish the school to contact:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Student Insurance Verification

Name of Health Insurer: _____ Student's Physician: _____

Policy #: _____ Expiration Date: _____ Physician's Phone: _____

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

I, _____, the parent or guardian of _____, recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstances.

Please make the following notation on my child's records:

Allergies to medications/food/latex/insect stings & bites/other: _____

Chronic conditions (indicate medication & condition): _____

Relevant medical information (e.g., contact lens, seizures, heart conditions, asthma, surgeries): _____

I give the school permission to share this information to protect the health and safety of my child or others.

Signature of Parent or Legal Guardian

Date

- It is the parent's responsibility to keep all information current throughout the school year.
- Dorchester Academy does not employ a school nurse to administer medication.