Emergency and Medical Information Card

Child's Name: _____ Date: _____

Home Address: _____
Street City State Zip

Mother's Name: _____ Father's Name: _____

Mother's Phone: _____ Father's Phone: _____

First Parent to Contact: _____ Student Date of Birth: _____ Gender: male female

Parents' Marital Status: _____ Student Resides With: _____

If Medical Care is Necessary, Call:

DOCTOR: _____
Name Address City State Zip Phone

Does your child have insurance coverage? **No** **Yes** Name of Insurance Company_____(Optional)

In case of injury or sudden illness, _____ will be called first. I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of an emergency, or if either parent above cannot be contacted to pick up my child, I hereby authorize the following person(s) to pick up my child. Please list anyone who may be routinely picking up your child here as well.

Name: _____ Name: _____

Telephone: _____ Cell phone: _____ Telephone: _____ Cell phone: _____

Name: _____ Name: _____

Telephone: _____ Cell phone: _____ Telephone: _____ Cell Phone: _____

If additional contact are needed, please write on the back of this form.

The following person(s) may **not** remove my child from the school:
Name: _____ Name:_____

Custody papers have been provided and are on file at the facility. yes no

Medical Information:

Is child allergic to food or other substances? **No** **Yes** (If yes, name foods or substances to be avoided and procedure to follow if reaction occurs.) _____
_____

Is child usually susceptible to infections and if so, what precautions need to be taken? **No** **Yes** _____
_____

Is child subject to convulsions and what should be our procedure if one occurs? **No** **Yes** _____
_____

Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? **No** **Yes** _____
_____

In the event your child may need over-the-counter medicine, do you consent to the staff at MCS administering it? No Yes
Please check all that applies: Tylenol___ Ibuprofen____ Cold Medicine____ Allergy Medicine_____ TUMS_____

Additional comments/other instructions: **Please include any supporting documentation on treating your child's specific health concerns.**

_____
_____

Parent Signature: _____ Date: _____