Community High School
District 155

STRIVE for success

Kimberly Morris

MEd, RN, PEL-CSN

STRIVE Transition Program 6000 Dvorak Drive Crystal Lake, Illinois 60012 815.479.0404

EMERGENCY CONSENT & MEDICAL INFORMATION FORM

Contact Information: Please check to be certain you have provided us with the correct phone numbers for each contact listed.

Today's Date:_____ Student Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip _____

Parent/Guardian Name: _____

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

Primary Email: _____ Secondary Email: _____

Parent/Guardian Name: _____

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

Other Emergency Contact: _____
Name Phone

Other Emergency Contact: _____
Name Phone

Medical Information: Please note here all diagnoses, hearing and vision issues, medications, hospitalizations, medical/health concerns, physical limitations, and allergies that may have implications in your child's educational program.

Name of Primary Medical Physician:_____ Phone:_____

Name of Dentist: _____ Phone: _____

Please list any specialists caring for the student, and what type of specialty medicine they practice:

_____

_____

_____

_____

_____

Does your student wear glasses? _____ Does your student have tubes in ears? _____

Does your student have hearing loss in one or both ears? _____

SEE REVERSE

List all Medical Conditions/Diagnoses: _____

Does your student have a shunt? If so, where? _____

Does your student have asthma? _____ If yes, is an inhaler needed at school? _____

Does your student have diabetes? _____ If so, do you have a current DMMP for school?_____

Has your student ever had a seizure? _____ When was the last seizure? _____ How frequent? _____

Recent illnesses, injuries, or hospitalizations?_____

List all medications your student receives:

Name	Amount	Frequency

List allergies to medications, foods, seasonal allergies, etc.:

Other information (if any)

I authorize the treatment by a qualified and licensed medical doctor to treat my student listed on this form in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her 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 and with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

_____

Parent/Guardian Signature Relationship to Student

Student Signature_____

SEE REVERSE