STUDENT EMERGENCY CONTACT CARD
Medical Information and Consent

STUDENT _____ **GRADE** 2013-14
Last First Middle

□ **MY CHILD HAS NO KNOWN HEALTH PROBLEMS** □ **MY CHILD HAS A POTENTIALLY LIFE THREATENING HEALTH CONDITION**

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication at school or at home? □**No** □**Yes**

- If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file.

Medication	Prescribing Physician	Dosage	Hours(s) Given

Vision and/or Hearing Problems:

□Wears glasses/contacts □Wears Hearing aids □Other (describe):_____

Medical Conditions: Please check the appropriate boxes if your child has any of the following:

□ **Severe Allergies**
□ Bees/insects □ Food □Environmental □ Medications
□ Other Explain:_____
Please Explain Reaction:_____
**Medications Needed* → □ Epi-Pen □ Benadryl □ Other_____

□ **Current Asthma** → *Uses* □ Inhaler □ On daily Medication □ No Medication required

□ **Current Seizures** → *If checked, On Medication?* □ Yes □ No

□ **Diabetes** → *If Checked, Insulin Dependent?* □ Yes □ No

□ **Migraines** → *If checked, On Medication?* □Yes □ No

□ Heart Condition: *Please Explain*_____

□ Attention Deficit Disorder → *On Medication?* □Yes □No

□ Emotional/Psychological Disorder: *Please Explain*_____ *Meds?* □Yes □ No

□ Swallowing, Stomach or Intestinal Disorder: Please Explain_____

□Other, *Please Explain*:_____

□ Recent Illness, hospitalization, or surgery. *If checked, please provide date(s) and description*:
_____

Physician/Health Care Provider:
_____
Phone No.(_____)-_____-_____

Dentist _____
Phone No. (_____)-_____-_____

Health Insurance Information:

Health Plan/Group Name:
_____

Policy No. _____

□ No Health Insurance

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the medicine practice act and the State of Wisconsin Department of Public Health.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

_____ *is the hospital I/we prefer for emergency medical treatment of my/our child.*

☐ Please check if you would allow your child to receive Tylenol, ibuprofen, antacids, cough drops, burn ointment, and antibiotic ointment at school if needed.

_____ _____/_____/_____
Parent/Guardian Signature Date