Lincoln Intermediate Unit 12
Leadership • Expertise • Innovation

SPECIAL MEDICAL/EMERGENCY INFORMATION

Student:
Last First M.

Teacher:

Location:

Program:

Name of Child's Doctor:

Address:

Telephone:

Address:

Date of Birth:

Dentist:

Please list any allergies the child has (including medication)

Seizures: Yes ☐ No ☐ Type:

Are there any physically handicapping conditions (include vision problems and/or Hearing problems) Yes ☐ No ☐

Type Severity

Does the child need to be transported with wheel chair, braces, crutches, walker, or prosthesis?

No ☐ Yes ☐ Type If Wheel Chair: Make Model

Has your child undergone any major operations or suffered serious illness or injury?

Yes ☐ No ☐ Explain

(Additional paper if more space is needed)

OFFICE USE ONLY

HIGH RISK Yes ☐ No ☐

Is your child receiving any prescribed medication? ☐ Yes ☐ No

Type Purpose

Is your child to receive this prescribed medication during school hours? ☐ Yes ☐ No

(If yes, the physician's report must be completed by the physician and signed by you prior to any administration of prescribed medication. No unprescribed medication (aspirin, cough syrup, etc.) will be administered without the physician's specific order. If the medication changes, a new physician's order must be completed. Any such medication sent into school must be clearly labeled with name of medication and prescribed dosage.

HIGH RISK INFORMATION: Description of medical condition which may present a critical problem to classroom teacher or bus driver:

Copy to: White–Transportation Office, Yellow-Driver, Pink-Teacher

SE-901A
Updated: 2/2020

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Student:
Last First M.

In case of emergency, illness, or accident, the school is authorized to proceed to notify the following people in order specified

1.

Parent Address (Work Phone)

(Home Phone)

2.

Parent Address (Work Phone)

(Home Phone)

3.

Parent Address (Work Phone)

(Home Phone)

In the event of a school emergency (snow, equipment failure) and no one is home when the child is returned home, indicate two persons who will receive your child.

1.

Name Address (Phone)

2.

Name Address (Phone)

I authorize that my child may be left alone at home when returned from school. ☐ Yes ☐ No

In the event of a medical emergency, you will be notified. However, it we are unable to contact you, we request permission for the following:

(1.) Use of antiseptics Yes ☐ No ☐

(2.) Notification of an available physician if necessary Yes ☐ No ☐

Doctor Phone

(3.) Transportation of your child to a hospital Yes ☐ No ☐

(4.) Name of Hospital

I hereby authorize the medication listed above to be administered to my child by the classroom teacher, school nurse, (or in certain emergency situations, the driver), if available. We do agree to hold the said employee harmless from any liability connected with the administration of medication and medically provided services at the times and in the manner set by the physician.

I hereby give my consent for my child to receive emergency treatment and will assume responsibility for any charges for treatment.

Parent(s) Signature

Date

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Updated: 10/2015