Emergency Medical Treatment Release/Health History Form

Dear Parent/Guardian

Please complete, sign, and return this form to the school on the next school day.

Student's complete name ____

Student's complete address ____

Student's phone number ____________________________ Date of Birth ____________

Student's school ________________________________ Grade ________________

Rides bus # ______ in the morning Rides bus # ______ in the afternoon

______ Is not transported by bus.

Family physician ____________________________ Physician's office phone __________

Routine medication student takes ____

____

Medication(s) student is allergic to ____

Student has a history of the following: ☐ heart disease; ☐ diabetes; ☐ nervous disorder; ☐ epilepsy;

☐ ear infection; ☐ seizure; ☐ asthma; ☐ nose bleeds; ☐ insect bite allergy; ☐ allergies

☐ Other: ____

Please describe these conditions ____

____

Please list any other pertinent health information ____

____

In case of emergency, accident, or serious illness of the above named child, I request the school to contact me. If I am unable to be reached, I authorize school/district personnel to obtain the emergency medical treatment necessary to maintain the student's health.

Parent/guardian signature ____

Relationship to student ______________________________________

Home phone number ______________________ Work phone number ________________

Review/Revised:7/21/2003