SPCHS MEDICAL EMERGENCY CARD *SCHOOL YEAR:* _____

STUDENT NAME: _____ DATE OF BIRTH: _____ GRADE: _____
(Last, First)

Home Address: _____ Home Phone: _____
(Street) (City, State & Zip))

Mother/Guardian: _____ Cell # _____

Place of Employment: _____ Work # _____

Father/Guardian: _____ Cell # _____

Place of Employment: _____ Work # _____

Designated contact person if parent or guardian is unable to be reached during school hours in case of an emergency, illness or injury. This person also is authorized to pick up student from school as needed:

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Is your child taking any medications? Yes___ No___

Name of medications: _____

Medication Allergies and symptoms: _____

Food Allergies and symptoms: _____

Does Food Allergy require the use of EPIPEN? Yes ___ No___ BENADRYL? Yes___ No___

Severe Bee Sting Allergy: Yes___ No___ If yes: EPIPEN? Yes ___ No___ BENADRYL? Yes___ No___

Asthma: Yes___ No___ If yes: Mild___ Moderate___ Severe___ Exercise Induced___ Date of last episode: _____

Medication: Yes___ No___ Inhaler___ Other Asthma Medication: _____

Seizures: Yes___ No___ Date of last Seizure: _____ Type: _____

Medication: Yes___ No___ Type: _____

Diabetes: Yes___ No___ If yes: Use of Pump_____ Pen_____ Injection_____ Other_____

Other special medical needs or considerations: _____

Health Care Provider Name: _____ Phone # _____

Does your child have health insurance? Yes ____ No____ If yes, type of insurance: _____

I authorize the school nurse or school personnel to arrange for medical assistance or transportation to a hospital at my expense if needed and to communicate with the health provider listed above as deem necessary. I understand that I must notify the school and school nurse with any changes of the information above.

Parent/Guardian Signature: _____ ***Date:*** _____