Emergency and Medical Information 2016-2017

Student's Name:				
Grade:	Date of Birth:	Age:	Gender:	Weight:

Please list all medical concerns:
Is the student allergic to food or other substances? Please list:
Is there any physical or medical condition that we should be aware of for this student?
If you have answered yes to any of the above questions, please provide a written health care plan prescribed by your physician. Blank health care plan are available in the health office.

PRESCRIPTION MEDICATION(s) to be given during school hours by school nurse: *All medications must be furnished by the parent in the original container with affixed prescription label. No more than a 30 day supply of medication should be brought to the health office. No medications will be accepted to the health office from a student/child.*

Medication Name	Route	Dosage Time	Special Instructions	Expiration Date	Reason for use	Possible side effects

I authorize the school nurse or the acting school nurse to dispense the above medications to my child: (parent initials) _____

SCHOOL STOPCK SUPPLY: Archway North Phoenix has my permission to administer the following to my child as needed according to package label instructions for dose and frequency:

Acetaminophen	Yes	No	Ibuprofen	Yes	No
Saltine crackers	Yes	No	Neosporin/antibiotic cream	Yes	No
Cough Drops	Yes	No	Benadryl	Yes	No
Saline eye drops	Yes	No	Antacid (Tums)	Yes	No
Anti-Itch Cream	Yes	No			

Primary Guardian 1 Name:		Home Address:	
Primary Phone:		Business Phone:	Other:
Primary Guardian 2 Name:		**Home Address:**	
Primary Phone:	Business Phone:		Other:
EMERGENCY CONTACT-Please list a different contact than Guardians listed above.			
Name:	Home Address:		
Primary Phone:	Business Phone:		Other:
Additional individuals who have my permission to collect my child from Archway North Phoenix:			
Name:			
Primary Phone:	Business Phone:		Other:
The following individuals *may NOT remove my child* from Archway North Phoenix			
Name(s):			

I hereby authorize any hospital/doctor/EMS personnel to render immediate aid as might be required at the time for his/her health and safety. I give consent/permission to release medical information regarding my child from any physician/hospital if required. It is understood by me that the expense of this service will be accepted by me. This Emergency Information is accurate and complete, and was provided by:

Parent Guardian PRINTED Name	Signature	Date