

EMERGENCY INFORMATION

In case of emergency, you may have permission to have me (student) treated by doctor on call at:

___ Spectrum Health United Memorial, Greenville ___ Other, specify: _____

Physician _____ Phone _____

Physician's Address _____

Emergency Contact #1 _____ Relationship _____ Phone _____

Emergency Contact #2 _____ Relationship _____ Phone _____

Emergency Contact #3 _____ Relationship _____ Phone _____

List any known allergies: _____

List any medication you are taking: _____

Other medical condition (check all that apply): Asthma Diabetic Epileptic Hemophiliac Bee Sting Allergy

Any other medical condition not listed above: _____

The Family Rights and Privacy Act requires your (parent/guardian) signature for disclosure of any medical problems your child may have. Your signature will allow release of medical information to school or medical personnel to better serve your child.

Parent/Guardian Signature: _____ Date: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated on this form and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangement necessary. Note to parents: No medications will be administered by school personnel without written directions from parent and physician.

Parent/Guardian Signature: _____ Date: _____

I affirm, that as the parent/legal guardian, all information provided above is true and accurate, and that my child and I reside at the listed address. I understand any false information provided by me may subject me to legal penalties for perjury.

Parent/Guardian Signature: _____ Date: _____

For office use only:

Drop Date: _____ Reason: _____