

IRVINGTON COMMUNITY SCHOOL INC. STUDENT MEDICAL EMERGENCY INFORMATION

School Year **2018 – 2019**

Student Name: _____ Grade: _____
Last First Middle

Date Of Birth: _____ Home Phone: _____

Student's Home Address: _____

Student Lives With (Check All That Apply): Mother Father Stepfather Stepmother Grandparent Other

Please Check the Following Box/Boxes Below to Indicate Child's Legal Custody

Father's Name: _____ Address: _____ Phone: _____

Mother's Name: _____ Address: _____ Phone: _____

Stepfather's Name: _____ Address: _____ Phone: _____

Stepmother's Name: _____ Address: _____ Phone: _____

Guardian's Name: _____ Address: _____ Phone: _____

Father's Workplace: _____ Phone: _____ Cell/Pager: _____ Email: _____

Mother's Workplace: _____ Phone: _____ Cell/Pager: _____ Email: _____

Stepfather's Workplace: _____ Phone: _____ Cell/Pager: _____ Email: _____

Stepmother's Workplace: _____ Phone: _____ Cell/Pager: _____ Email: _____

Guardian's Workplace: _____ Phone: _____ Cell/Pager: _____ Email: _____

In Case of Emergency When Parents Cannot Be Located, Whom Should We Contact LOCALLY?

Name: _____ Home Phone: _____ Work Phone: _____ Cell: _____
(1st Choice) Relationship

Name: _____ Home Phone: _____ Work Phone: _____ Cell: _____
(2nd Choice) Relationship

Name of Primary Care Physician: _____ Phone: _____

Other Health Care Provider: _____ Phone: _____

Other Health Care Provider: _____ Phone: _____

List any physical limitations or medical problems: _____

Allergies (list) _____

Asthma: Yes No If **Yes** to Asthma, please list and explain: _____

Seizures: Yes No If **Yes** to Seizures, please list and explain: _____

List Medications the Student is Currently Taking:

<u>Medication Name</u>	<u>Dosage</u>	<u>Times Taken</u>	<u>Prescribed By</u>	<u>Purpose</u>

Emergency Treatment Procedure Notification, Student Medical Information Disclosure, and Parent/Guardian Signature

1. In case of an emergency involving your child, it is the policy of ICS to render first aid treatment while contacting parents/guardians for further instructions. In the event that the parents/guardians cannot be contacted, school officials will contact 911.
2. By signing this form I consent to the release of information between ICS personnel and the student's primary care physician and other health care providers.
3. Information on this form may be shared with the appropriate ICS and EMS personnel for health and emergency purposes.

Hospital Preference: _____

Parent or Guardian (Print): _____ Date: _____

Parent or Guardian (Sign): _____ Date: _____

Insurance Coverage: Yes No