

**2010-2011 OVERBROOK SCHOOL EMERGENCY/ILLNESS INFORMATION**

Student's Name \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B \_\_\_\_\_ Grade \_\_\_\_\_

Mother \_\_\_\_\_ Employer \_\_\_\_\_ WK Phone \_\_\_\_\_

Mother's Mobile Phone \_\_\_\_\_ Father's Mobile Phone \_\_\_\_\_

Father \_\_\_\_\_ Employer \_\_\_\_\_ WK Phone \_\_\_\_\_

Home Address \_\_\_\_\_ HM Phone \_\_\_\_\_

**\*\*\*\*For Emergency or illness, please state parent to be called\*\*\*\***

1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_

Name of person(s), other than parent, authorized to act for parent in an emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Student's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Student's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Preference of Hospital to transport child in an emergency \_\_\_\_\_

Insurance Information: Name of Insured \_\_\_\_\_ Ins. Co. \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Medical History-Does student have any of the listed conditions?

Asthma _____	Arthritis _____	Bee Sting Allergy _____
Diabetes _____	Kidney/Bladder _____	Seizure Disorder _____
Hearing Loss _____	Visual Impairment _____	Wear glasses/contact lenses _____
Fractures _____	Heart Disease _____	Headaches/Migraines _____

Any other medical problem/history that should be communicated to health professionals in the event of an emergency \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Allergies-medication and/or food \_\_\_\_\_

Diet Restrictions \_\_\_\_\_

Physical limitations or activity restrictions \_\_\_\_\_

\*\*Letter from child's physician will have to be sent to the school stating the restrictions and the reason\*\*

Medication-Name \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

List all persons to whom your child *may not* be released:

(Parent must provide proper legal documentation to support this request)

Name \_\_\_\_\_ Name \_\_\_\_\_

***Medical Release: In case of serious accident or illness, I authorize school personnel to take emergency measures to protect my child. I request the school to contact me. If the school cannot reach me, I authorize the school to call my child's physician indicated on this form and follow his/her instructions. If physician is not available, I authorize the school to take my child to the emergency room.***

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date