



**MEDICAL EMERGENCY FORM -2010-2011**  
**ST. EDMUND'S ACADEMY**  
**PLEASE PRINT CAREFULLY**

NAME OF STUDENT

Last: \_\_\_\_\_ First: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

PARENT/GUARDIAN 1 NAME & HOME TELEPHONE NUMBER: \_\_\_\_\_

PARENT/GUARDIAN 2 NAME & HOME TELEPHONE NUMBER: \_\_\_\_\_

PARENT/GUARDIAN 1 WORK PLACE AND PHONE: \_\_\_\_\_

PARENT/GUARDIAN 2 WORK PLACE AND PHONE: \_\_\_\_\_

CELLULAR PHONE(S) Parent/Guardian 1: \_\_\_\_\_ Parent/Guardian 2: \_\_\_\_\_

**If neither parent can be reached in an emergency, please contact:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME AND PHONE OF CHILD'S PEDIATRICIAN: \_\_\_\_\_

NAME AND PHONE OF CHILD'S DENTIST: \_\_\_\_\_

NAME AND POLICY NUMBER OF FAMILY HEALTH INSURANCE: \_\_\_\_\_

HOSPITAL OR ER PREFERENCE: \_\_\_\_\_

Circle any health condition(s) that your child may have: ASTHMA    DIABETES    EPILEPSY    ALLERGIES

Other conditions: \_\_\_\_\_

Food/drug allergies: \_\_\_\_\_

Please list ALL medications your child is currently taking: \_\_\_\_\_

In addition to first aid, my child may be treated at the normal children's dosage as needed in the judgment of the School Nurse or authorized school personnel:

IBUPROFEN Yes / No  
(ex.: Advil/Motrin)

ACETAMINOPHEN Yes / No  
(ex.: Tylenol)

ANTIHISTAMINE Yes / No  
(ex.: Benadryl)

By my signature below, I give consent to the school to carry out any item(s) indicated by "Yes" responses above.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

If there is a medical emergency, and no parent can be contacted, I give permission to St. Edmund's Academy faculty/staff to oversee required medical procedures. I also give permission to EMS Personnel and Emergency Room Physicians to perform needed emergency procedures.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**PLEASE RETURN THIS FORM BY JUNE 1<sup>ST</sup>**