



STUDENT EMERGENCY INFORMATION

DATE: _____

STUDENT'S NAME _____ DATE OF BIRTH _____
 (LAST) (FIRST) (MIDDLE)

ADDRESS _____ PRIMARY PHONE _____
 (STREET) (CITY) (ZIP CODE)

S.S # _____ MEDICARE # _____ MEDICAID # _____

TRANSPORT PROVIDER/PH # _____ CELL # _____

	NAME	ADDRESS	PHONE	EMPLOYER/PHONE
Mother/Responsible Party				
Father/Responsible Party				
Provider Name/Contact (if applicable)				
Court Appointed Guardian				

BACKUPS: Identify two neighbors or relatives with a local telephone and available transportation who have agreed to relay a message and/or pick up the student in an emergency:

1) _____

2) _____

NAME ADDRESS PHONE

HEALTH INFORMATION

STUDENT'S: HEIGHT: _____ Feet _____ Inches WEIGHT: _____ lbs. AGE: _____ Yrs.

Last Physical Exam: _____ Last Vision Exam: _____ Last Dental Exam: _____
 (DATE) (DATE) (DATE)

Immunizations Last Year: Type/Date: _____ Last Tetanus Date: _____

HEALTH/MEDICAL PROBLEMS	PHYSICAL LIMITATIONS	DIET INFORMATION	ALLERGIES

LIST ALL CURRENT MEDICATIONS THE STUDENT TAKES DAILY, WHETHER AT HOME/SCHOOL. IF NO MEDICATION IS TAKEN, WRITE NONE.

NAME AND DOSE OF MEDICATION	NAME AND DOSE OF MEDICATION	NAME AND DOSE OF MEDICATION

NOTE: IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO INFORM THE SCHOOL NURSE IMMEDIATELY OF CHANGES IN THIS INFORMATION. SERVICES MAY BE INTERRUPTED IF CURRENT EMERGENCY INFORMATION IS NOT PROVIDED.

SEIZURE INFORMATION

Does the student have seizures? Yes No if yes, date of last seizure _____

How long does a seizure last? _____ (seconds/minutes) how often do they occur? _____

BEFORE, DURING, OR AFTER A SEIZURE, DO ANY OF THE FOLLOWING OCCUR? (Please check)

- Cries Out Rolls Eyes Urinates Twitching Becomes Confused Becomes Rigid
- Falls down Skin Color Changes Becomes Unconscious Body Jerks Vomits

FIRST AID

Do you consent to the program staff administering first aid in case of illness or injury to the student during the program day? Yes No

If yes, I agree to hold harmless the Medina County Board of Developmental Disabilities and its 'employees for any injury resulting from administration of such first aid.

Parent/Guardian Signature

Date

IMPORTANT - YOU MUST COMPLETE AND SIGN EITHER PART I OR PART II BELOW - IMPORTANT

Part I

GRANT OF CONSENT

In the event reasonable attempts to contact me at _____ or to contact _____ at _____
 _____ (Phone number) _____ (Other parent/guardian)
 _____ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed
 _____ (Phone number)
 Necessary by Dr. _____ or
 _____ (Physician) _____ (Address) _____ (Phone)
 Dr. _____ or in the event
 _____ (Dentist) _____ (Address) _____ (Phone)
 These are not available, by any other licensed physician or dentist, and (2) the transfer of the student to
 _____ or any hospital reasonably accessible.
 _____ (Preferred hospital)

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature

Date

-OR-

Part II

REFUSE TO CONSENT

I DO NOT give my consent for emergency medical treatment of this student. In the event of illness or injury requiring treatment, I wish program authorities to TAKE NO ACTION or to:

Parent/Guardian Signature

Date