

## STUDENT MEDICAL INFORMATION 2021/2022

\_\_\_\_\_  
Last Name (Print)                      First Name                      DOB                      Grade                      Teacher

\_\_\_\_\_  
Home/Primary Phone                      Mother's Work/Cell Phone                      Father's Work/Cell Phone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Family Doctor                      Daytime Phone                      Hospital Preference

\_\_\_\_\_  
Health Plan/Insurance (i.e. Blue Cross, Kaiser)                      Group/Policy No.

My child is allergic to the following medications: \_\_\_\_\_

Other medications used: \_\_\_\_\_

My child has the following health problems: \_\_\_\_\_

\_\_\_\_\_  
Name and phone number of local relative or friend to contact in case parent/guardian cannot be reached:

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Over 

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\_\_\_\_\_  
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Over 

## **AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

As legal custodian of \_\_\_\_\_, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Evergreen Union School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, x-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the Evergreen Union School District does not provide accident medical insurance for students for school related injuries, but does offer student accident insurance for voluntary purchase. I have received the information and application for this program.

**PLEASE CHECK:**  I will enroll my child in the program.  I will not enroll my child in the program.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

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