STUDENT MEDICAL INFORMATION 2019/2020

_____

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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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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