

Sturgis Charter School

EMERGENCY MEDICAL INFORMATION

Student's Biographical Information:

Name (first, middle, last): _____ Grade: _____ Date of Birth: _____

Residential Address: _____

Mailing Address: _____

Student's Regular Physician:

Name (first, middle, last): _____ Phone (including area code): _____

Student's Medical History:

Please list any/all medical conditions including allergies:

Medications the student is presently taking including as needed medications:

Other pertinent medical information:

Student's Medical Insurance Information:

Company: _____

Plan Number: _____

Policy Holder: _____

Emergency Contacts

Custodial/Primary Parent or Guardian

Name (first, middle, last): _____

Resides with student: ___Yes ___No

Daytime Phone (including area code): _____

Evening Phone (including area code): _____

Parent or Guardian

Name (first, middle, last): _____

Resides with student: ___Yes ___No

Daytime Phone (including area code): _____

Evening Phone (including area code): _____

Other Contact

Name (first, middle, last): _____

Phone (including area code): _____

Relationship (friend, neighbor, coworker, etc.): _____

Other Contact

Name (first, middle, last): _____

Phone (including area code): _____

Relationship (friend, neighbor, coworker, etc.): _____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the school. A copy of this information may be given to a faculty member assigned to supervise your child in the event of a field trip or school outing. Should the need arise, this information will be given to the proper medical authorities.

I, _____ [parent/guardian], understand that in the case of illness or injury to my child, _____ [child's name], the school will try to notify me or the person I have listed above as an emergency contact. In the event that I cannot be reached, I grant full power to Sturgis Charter Public School to 1) contact emergency medical services and/or arrange transportation to the nearest medical facility for treatment and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature of Parent/Guardian

Date

This Authorization for Emergency Medical Treatment is valid for a period of one year, from September __, 20__ through September __, 20__.