

Weakley County Schools Student Medical/Accident Information Form (5/12)

Parents/Guardians: Please provide the most accurate information possible regarding your student. Please print clearly and with enough pressure to ensure the information will be copied on all pages.

Student Name: _____ Date of birth: _____
Last name First Name Middle Initial

Address: _____ **Home phone:** _____

Father: _____	Cell phone: _____
Address: _____	Home phone: _____
Employer: _____	Work phone: _____
Email: (home) _____ (work) _____	Additional phone: _____
Mother: _____	Cell phone: _____
Address: _____	Home phone: _____
Employer: _____	Work phone: _____
Email: (home) _____ (work) _____	Additional phone: _____

Please provide contact information for Two (2) Emergency Contacts

Emergency Contact: _____	Home phone: _____
Cell phone: _____ (work) _____	Relationship: _____
Emergency Contact: _____	Home phone: _____
Cell phone: _____ (work) _____	Relationship: _____
Physician preferred: _____	Phone: _____
Hospital preferred: _____	Phone: _____

Brief Health Background: Please list medical conditions for which your student is currently being treated or which may be helpful for the nurse or other healthcare provider to be aware (i.e. history of asthma, seizures, headaches, etc.)

Please list any medications your child is currently taking (please provide dosage if known)

Note: medications which are to be given by school staff MUST be in the original container and include instructions/permission to administer. The student's name must be clearly affixed to the prescription bottle or over the counter medication. See student handbook for complete instructions.

Allergies: Has your child ever experienced an allergic reaction to medicine(s)? Please list: _____

Is your child allergic to food items or insect bites? yes no if you answered "yes" please list the specific items: _____

Does your child carry an "Epi-Pen"? yes no Does your child use any of the following (please mark any that apply):

Glasses yes no contacts yes no dental devices yes no

wheelchair/walker yes no hearing aids? yes no

Does the school nurse have permission to give the following per labeled directions?

Acetaminophen (Tylenol) Yes No or Ibuprofen (Motrin) Yes No (for pain or fever)

Tums (calcium carbonate) Yes No or Pepto-Bismol (bismuth subsalicylate) Yes No or Rolaids (calcium carbonate/magnesium sulfate) Yes No (for upset stomach)

Benadryl (diphenhydramine HCl) Yes No (for allergic reaction to insect bites or food and we are unable to reach you)

Signature of person completing form: _____ Date: _____
Relationship to student: _____

In case of an accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements which may seem necessary. I agree to pay for any medical costs incurred for emergency treatment.