STUART HALL SCHOOL for BOYS
2013-2014 EMERGENCY INFORMATION AND MEDICAL HISTORY

IT IS VERY IMPORTANT THAT THIS FORM BE RETURNED TO THE SCHOOL BY FRIDAY, JULY 26TH, AND THAT YOU REPORT ALL HEALTH INFORMATION. YOUR CHILD MAY NOT ATTEND CLASS IF THIS FORM IS NOT ON FILE.

Student's Name _____
Last First Nickname

Grade _____ Date of Birth _____

_____
Address City State Zip

Mother/Guardian's Phone Information:

Mother's Name _____ Home Phone _____

Office Phone _____ Cell # _____ Email: _____

Father/Guardian's Phone Information:

Father's Name _____ Home Phone _____

Office Phone _____ Cell # _____ Email: _____

Person to notify if unable to reach parent/guardian:

Name Daytime Phone Relationship to Student

_____

_____

_____

People authorized to pick up my child:

Name Daytime Phone Relationship to Student

_____

_____

_____

_____

_____

(PLEASE TURN OVER)

Student Name:_____ DOB_____ Grade_____

Student's Physician _____ Phone _____

Physician's Address_____Hospital Used by Physician _____

Health Insurance Company _____ Policy No. _____

Student's Dentist_____ Phone_____

Dentist's Address _____

MEDICAL HISTORY

Health conditions and/or chronic illnesses of student for emergency use. **Example:** Diabetes, Arthritis, etc. Is this confidential or should teachers be notified? _____

_____

_____

Health problems which may affect classroom work or ability to learn. Information will be forwarded to teachers. **Example:** Vision, hearing, educational or psychological evaluation, etc. _____

_____

_____

Allergies: **To What** **Reaction**
Usual Treatment

_____ _____

_____ _____

_____ _____

Medication taken regularly or frequently by student:

_____

I, the undersigned parent/guardian, authorize the representative of Stuart Hall School for Boys to obtain medical, surgical, or dental care for my child in the event of accident, injury, or illness. Permission is hereby granted to the licensed physician or accredited hospital and their associates to perform any medical, dental, and/or surgical procedures that are deemed essential to the treatment of my child. I also agree to be responsible for payment of such care.

Signed: _____ Date _____