



Emergency Medical Information – (The information provided on this card is kept in a secure & confidential file).

Physician \_\_\_\_\_ City \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Phone # \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_

Health information – (Please answer each of the following, if they do not apply to your daughter write N/A)

1. Diagnosed Conditions: \_\_\_\_\_ Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Epilepsy \_\_\_\_\_ Other \_\_\_\_\_
2. Allergies to Medications: \_\_\_\_\_
3. Routine Medications: \_\_\_\_\_
4. Vision/Hearing Challenges: \_\_\_\_\_ Needs Preferential seating \_\_\_\_\_ Hearing loss \_\_\_\_\_ Corrective lenses \_\_\_\_\_
5. Any physical limitations: \_\_\_\_\_
6. Does this student receive special accommodations due to any IEP, 504 Plan or doctor recommendation? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

My signature below authorizes any licensed physician to render necessary emergency treatment for injury or serious illness when neither parent can be reached and I will assume financial responsibility for such treatment. My signature authorizes SJHS to choose the doctor and hospital in the event of an emergency.

CONTACTS DURING SCHOOL HOURS FOR STUDENT RELEASE (Called if parent(s)/guardian(s) cannot be reached)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_

Other children in the family	DOB	F/M	Grade	School

\_\_\_\_\_  
Mother/Guardian SIGNATURE DATE

\_\_\_\_\_  
Father/Guardian SIGNATURE DATE