

Meadows Valley School District # 11
EMERGENCY MEDICAL RELEASE FORM

Student _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Family Email Address _____

Parent/Guardian Phone Numbers:

Mother/Guardian

Name _____ Relationship _____

Home Phone(_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

Father/Guardian

Name _____ Relationship _____

Home Phone(_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

Telephone numbers of friends or relatives the school personnel can contact if parents can not be found.

1) Contact Name _____ Relationship _____

Home Phone(_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

2) Contact Name _____ Relationship _____

Home Phone(_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

3) Contact Name _____ Relationship _____

Home Phone(_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

Family Physician _____ Phone _____

Family Dentist _____ Phone _____

Check any current health problems your child has:

- | | |
|--------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> No Known Health Problems | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Blood Disorder _____ | <input type="checkbox"/> Environmental hypersensitivity to _____ |
| <input type="checkbox"/> Food Allergy to: _____ | <input type="checkbox"/> Potentially severe reaction to _____ |
| <input type="checkbox"/> Heart Problem _____ | <input type="checkbox"/> Neurological Disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Muscular Disease _____ |
| <input type="checkbox"/> Seizures: type _____ | <input type="checkbox"/> Skin Problems _____ |
| <input type="checkbox"/> Genetic syndrome _____ | <input type="checkbox"/> Psychological Diagnosis _____ |
| <input type="checkbox"/> Glasses/Contacts _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Hearing Aid (R) _____ (L) _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hearing/Visual Impairment (specify) _____ | |

ADD/ADHD _____

Receiving medication:

Yes No IF YES, name of medication _____

Is this medication needed at school? Yes No

Child is able to take PE/Recess? Yes No *If NO, must provide medical documentation of limitations

My student may take at school:

- Acetaminophen (Tylenol) Ibuprofen (Advil/Motrin)

In the event of serious illness or injury, your family physician is not available or is not located in the immediate vicinity and we are unable to contact one or both parents, does the district staff have your permission to seek medical attention from the nearest physician? _____ YES _____ NO If you answer "NO" please specify the procedure you wish the district staff to follow: _____

If an emergency arises while your child is participating in an activity away from home, do you consent to an examination and/or treatment by a physician recommended by the host school authorities? _____ YES _____ NO If answered "NO" please specify the procedure you wish our staff to follow: _____

Parent Signature

Date

Please return to your school office.