

EMERGENCY & HEALTH INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ GRADE/TEACHER _____

NAMES/PHONE NUMBERS:

MOTHER/GUARDIAN _____ HOME _____

CELL _____ WORK _____

FATHER/GURADIAN _____ HOME _____

CELL _____ WORK _____

****ADULTS AUTHORIZED TO PICK UP YOUR CHILD IF PARENT/GUARDIAN NOT AVAILABLE****

1. NAME _____
ADDRESS _____
NUMBER _____

2. NAME _____
ADDRESS _____
NUMBER _____

DO NOT RELEASE TO (IF APPLICABLE) _____

HEALTH INFORMATION:

ALLERGIES _____

MEDICATION TAKEN REGULARY _____

MEDICAL CONDITIONS _____

STUDENT PHYSICIAN _____ PHONE NUMBER _____

STUDENT DENTIST _____ PHONE NUMBER _____

GLASSES/HEARING AIDS _____

OVER

HEALTHCARE AUTHORIZATION

HEALTH OFFICE MAY DISPENSE ADVIL, TYLENOL, CALAMINE,
HYDROCORTISONE CREAM, ORAGEL, BENEDRYL, COUGH DROPS,
ANTIBIOTIC OINTMENT, TUMS YES _____ NO _____

I AUTHORIZE SCHOOL PERSONNEL TO OBTAIN HEALTHCARE
INFORMATION REGARDING MY STUDENT.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

I REQUEST THE SCHOOL TO CONTACT ME. IF I CANNOT BE REACHED, I
AUTHORIZE SCHOOL PERSONNEL TO SEEK EMERGENCY MEDICAL CARE,
INCLUDING TRANSPORTATION TO THE EMERGENCY ROOM. I AUTHORIZE
THE ER DOCTOR TO ADMINISTER WHATEVER TREATMENT IS NECESSARY
AT MY EXPENSE.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

HEALTHCARE INFORMTATION-FOR STATE OF VERMONT STATISTICS-TO
PROMOTE HEALTH ACCESS TO ALL CHILDREN

DOES THIS CHILD HAVE HEALTH INSURANCE YES NO

Did this child see a medical provider for a physical in the past year? Date _____

Did this child see a dentist for a dental check up in the past year? Date _____

SIBLINGS IN WINOOSKI SCHOOL DISTRICT
