2023-2024 Emergency Health & Contact Information

Student Name:	Grade:	DOB:
Address:		
Parent/Guardian:		

Primary Phone:	Cell Phone:
Work Phone:	Email:

Sports Participation: Please fill in all that apply: Example: Fall: Football	Fall Sport	Winter Sport	Spring Sport
Emergency lodging in Caledonia for severe weather:			
Sibling (s) Name/Grade:			

PRIMARY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	
Name/Relationship:	Phone #:
SECONDARY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	
Name/Relationship:	Phone #:

I understand that by listing the contact people above that I give permission for any of them to provide transportation for my child in the event of illness and/or injury.

Known medical conditions/allergies:

Breathing Difficulties? Yes No Describe:

Asthma? Yes No If "Yes" do they carry an inhaler: Yes No	If allergy do they carry an EPI pen: Yes No If they have a reaction describe the symptoms to look for:

If Diabetic: Yes No Do they carry insulin/food with them: Yes/Specify: ___________________________ No

Current Medications:

Primary Care Physician:

Preference for medical clinic/hospital in case of emergency transfer:

Insurance Information:

*I give permission to share the health concerns written on this card with school personnel for the purpose of ensuring efficient and accurate treatment in a health crisis. I verify that the information provided on this form is accurate. I understand that I am responsible for providing updated information. I have completed the reverse side of this form. This permission is good for the 2023-2024 school year.

Parent/Guardian Signature: Date:

<u>**ONLY SIGN THIS SECTION IF YOUR SON/DAUGHTER IS INVOLVED IN A SPORT**</u>

I consent to my child being cared for by certified Athletic Trainer on site or if none is present for the coaching staff to assist with care of my son/daughter. I also consent for emergency transport if deemed necessary.

Parent/Guardian Signature: Date:

Please fill out backside of form also. Thank You!

Caledonia School District Parent/Guardian Consent for OTC medications, prescription medications AND procedures.

Student Name:	DOB:	Grade
Medication:	Dose:	Time:
Medication:	Dose:	Time:
Medication:	Dose:	Time:

Important Information:
Please read to ensure you know what you are granting permission for:

x I hereby grant permission for my child to take OVER THE COUNTER (OTC) medications at school.

x I agree to provide the school with the OTC medication in a properly opened bottle. x I will provide the school with written notification of any change in the medication (dosage change or medication is discontinued).

x If student is taking prescription medications during school, a physician's order, signature and parents signature is to be provided prior to administration of a prescription medication.

x I give my permission for the school nurse to communicate with my child's teachers about the action and side effects of this medication.

x I give permission for the school nurse to contact my physician regarding any questions about this medication or the medical condition being treated by this medication.

x I agree to release the school district from any and all liability claims arising from the administration of this medication at school.

Parent/Guardian Signature:	Date:	Phone #:
Physician's Signature	Date:	Phone:

***Parent's signature required for ALL medications.**

***Physician's signature for ALL prescription medications.**