

2025-2026 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	<u>Fall Sport</u>	<u>Winter Sport</u>	<u>Spring Sport</u>
Emergency lodging in Caledonia for severe weather:			
Sibling (s) Name/Grade:			
<b>PRIMARY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY</b>			
Name/Relationship:		Phone #:	
<b>SECONDARY PERSON TO BE NOTIFIED IN CASE OF EMERGENCY</b>			
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 allergy do they carry an EPI pen: Yes No
If "Yes" do they carry an inhaler: 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 2025-2026 school year.	
Parent/Guardian Signature:	Date:
<b><u>**ONLY SIGN THIS SECTION IF YOUR SON/DAUGHTER IS INVOLVED IN A SPORT**</u></b>	
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:
<p><b>Important Information:</b>  <b>Please read to ensure you know what you are granting permission for:</b></p> <p>× I hereby grant permission for my child to take <u>OVER THE COUNTER (OTC)</u> medications at school.</p> <p>× I agree to provide the school with the OTC medication in a properly opened bottle. × I will provide the school with written notification of any change in the medication (dosage change or medication is discontinued).</p> <p>× 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.</p> <p>× I give my permission for the school nurse to communicate with my child's teachers about the action and side effects of this medication.</p> <p>× 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.</p> <p>× I agree to release the school district from any and all liability claims arising from the administration of this medication at school.</p>		
Parent/Guardian Signature:	Date:	Phone #:
Physician's Signature	Date:	Phone:

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

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