EMERGENCY CONSENT AND MEDICAL INFORMATION FORM 2016-2017

Student_____ **Birthdate**_____**Grade**____
Physican's Name_____ **Phone #**_____
Dentist's Name_____**Phone #**_____
Health Insurance_____
ID # _____

MEDICAL INFORMATION:

Does your child have allergies? ___ Yes/No To What?_____
Anaphylaxis? ____Yes/No
Describe allergic reaction/treatment: _____
Epi-Pen?_____
Any medical problems/conditions
(i.e.asthma)_____
_____
Any specific instructions/treatments:
_____
Medications currently taken at home:
_____
Will this be needed on field trips? ___ Yes/No
Other medical information:
_____
Any physical restrictions or accommodations requested:
_____

The School Nurse may administer to my child the following medications as needed:

__ Advil ___ Tylenol __ Benadryl __ Tums __ Cough Drop

CONSENT FOR MEDICAL TREATMENT AND LIABILITY WAIVER

I recognize that children may get hurt at The Foote School or during athletic and other activities related to The Foote School. I release and hold harmless The Foote School, its agents, and employees from all claims, damages and other liability for injury to the student where such claims, damages or other liability are not the result of gross negligence by The Foote School, its agents or employees. I hereby give The Foote School the authority to obtain any necessary medical treatment for my child, if in the judgment of staff treatment is required. I give my permission to the school to release medical information to school staff/faculty and health care providers as necessary. I am aware that if my child self-carries an Epi-pen or inhaler to school it is my responsibility to make certain my child carries the medication to school each day and on all school-related activities. I also give my permission to staff to administer medications in accordance with instructions provided by the school nurse or myself. In the event of an emergency, I also authorize the school-activity chaperones to act on my behalf when seeking medical treatment. In the event I cannot be reached, I authorize medical treatment as deemed necessary by the attending physician or other health care provider.

I understand that I am financially responsible for any expenses for medical care or transportation incurred on my child's behalf.

Parent 1/Guardian Signature _____ Date _____
Parent 2/Guardian Signature _____ Date _____

Preferred Medical Facility (Please circle)
Yale-New Haven Hospital St. Raphael Yale Health Other_____