

MARBLEHEAD PUBLIC SCHOOLS EMERGENCY MEDICAL INFORMATION

Student: _____ M/F _____
Last Name, First Name, Middle Name Team/Home Room/Grade

Date of Birth: Yr _____ Mo. _____ Day _____

Primary Emergency Contact: _____
Name Tel.#

Secondary Emergency Contact: _____
Name Tel.#

Health Conditions
Allergies
Daily Medications
Past Concussions Y/N Date: _____ Date of last physical: _____

Doctor: _____ Tel.# _____

Insurance _____ Policy # _____

Dentist: _____ Tel.# _____

In the event of an EMERGENCY, I hereby authorize the school authorities to have my child transported to a hospital and treated by a physician. Every effort will be made to reach parent/guardian or persons designated on top of card.

I hereby authorize designated school authorities to administer OVER-THE-COUNTER medications (such as Tylenol), according to approved school protocols.

I authorize the school nurse to leave phone message pertaining to my child's health on the voice-mail of the emergency numbers provided above.

I hereby authorize the exchange of information between Marblehead Public Schools and any Health Service Provider/Agency for my child. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent/Guardian Signature

Date