

STUDENT CLINIC CARD**Stock # 90860**

Revised 08/04/16

Grade _____

School _____ **School Year** _____

Teacher _____ Bus# _____

Student Name (Last, First): _____

Student ID: _____

Address: _____

Date of Birth _____

Parent / Legal Guardian Information

Mother's Name: _____

Father's Name: _____

Tel. #(home): _____

Tel.# Father (home): _____

Mother (work): _____

Father (work): _____

Mother (cell): _____

Father (cell): _____

Email Address: _____

Email Address: _____

Medical Information

Doctor's Name: _____

Doctor's Tel #: _____

Hospital Preference: _____

In the event the parent/guardian cannot be reached, the following are authorized to pick up my student

Name	Relationship	Telephone

I understand that in the event the parent/guardian cannot be reached, the school has my permission to take appropriate emergency action including calling 911.
 I understand it is also my responsibility to update the school as needed regarding any medical information which may impact my child during the school day.

 Signature of Parent / Legal Guardian

List any **MEDICATIONS** taken routinely and reason taken

Medications

Reason Taken

Emergency Medications:

CURRENT MEDICAL CONDITIONS that the school staff should be aware of (such as asthma, seizure disorder, diabetes, bleeding disorder, heart or stomach problems, mental health - ADD/ADHD, bipolar, anxiety, autism, etc.)

Does your student need a HEALTH PLAN sent home for you to complete in order for this condition to be managed at school?

No

Yes

_____ INITIALS

List the **ALLERGIES** that your student has (such as food, insects, environmental, etc.):

Does your student need an allergy emergency plan for school?

No **Yes** _____ **INITIALS**

List others in your household attending G PS schools

Name	Relationship	School Attending

PLEASE FILL OUT MEDICAL INFORMATION ON REVERSE SIDE

