

THE ADELSON EDUCATIONAL CAMPUS EMERGENCY DATA AND MEDICAL HISTORY



Student's Name _____

Address _____

Date of Birth _____ Grade _____

Father/Guardian Name _____ Home Phone _____

Cell Phone _____ Email _____

Mother/Guardian Name _____ Home Phone _____

Cell Phone _____ Email _____

Health Issue	Yes	No	Health Issue	Yes	No
Diabetes: Type1/Type 2			Seizures Type		
Hypoglycemia			ADD/ADHD		
Lung Problems			Bipolar Disorder		
Asthma Type/Reactive Airway Disease			Autism/Asperger's		
Heart Problems			Depression/Anxiety		
Hearing Problems/Hearing Aid			Orthopedic Problem		
Neurological Disorder			Visual Impairment		
Skin Disorder			Glasses/Contacts		
Bleeding Disorder			Migraine/Cluster Headaches		
Endocrine Disorder			Gastrointestinal Problem		
Other			Physical Disability		

Student's Physician _____ Phone _____

Medical Insurance: Policy # _____ Group # _____

Student's Dentist _____ Phone _____

EMERGENCY CONTACTS:

Emergency Contact Name Relationship to Student Phone Number

Emergency Contact Name Relationship to Student Phone Number

EMERGENCY POLICY:

1. The emergency contact name listed above is a person who has agreed to be designated by you to take full responsibility for your child in case of medical need when no parent can be reached by phone. It is most important to keep your emergency contacts current, available by phone and knowledgeable about the responsibility you have given them.
2. Authorization Form: We require that this form be placed on file in case of a serious accident in which the school is totally unable to reach either parents/guardians or emergency contacts. Because of liability problems, hospitals and doctors will refuse medical care for your child unless presented with authorization from the parents/guardians. As time can be essential in a medical emergency, this form assures your child of prompt medical attention. You may wish to provide your physician, dentist and your emergency contact with the same authorization form. We will do everything possible to reach parents in any case of illness or accident.
3. This authorization is effective from the date of signature until the end of the next school year.

Authorization for Pediatric Emergency Medical and/or Surgical Treatment

In case of emergency, I hereby consent to any dental, medical or surgical diagnosis and treatment, including hospitalization, to be rendered to the minor at a recognized medical facility. This authorization applies to all school-sponsored programs.

Signed _____ Relationship to Student _____ Date _____