

obbs Municipal Schools Emergency Information & Permission Form

Student ID #: Last Name: First Name: MI: Sex: M F Enroll Date: Date of Birth: Address: Home Phone: Language Spoken at Home: PRIMARY FAMILY CONTACTS (WHO THE SCHOOL SHOULD CALL FIRST) Parent/guardian name: Relationship: Work number: Cell number: Lives with: Y N Parent/guardian name: Relationship: Work number: Cell number: Lives with: Y N EMERGENCY CONTACTS (WHO THE SCHOOL SHOULD CALL FIRST) FRelationship: Home Phone: Cell: Work: Name: Relationship: Home Phone: Cell: Work: TO GRANT CONSENT - In case of emergency involving my child and Learnot be reached, I hereby give my consent to transport my child the following medical care providers and hospital and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary: Primary Care Provider: Provider: Physician Assistant) Dentist: Phone #: Preferred Hospital: FACTS COndition Providers Condition Problems Occurred ADHD/ADD Seizures Meninglits Asthma High Blood Pressure Meninglits Figh Blood Pressure Meninglits Figh Blood Pressure Meninglits Finglity yes Index on the parallysis Froblem Condition Problems Type: Finglity yes Index on the parallysis Finglity yes Index on the parallel problems Finglity yes Index on the p	School:		TEACHER:				Grade:	
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Type: Type: Type: Other								
	Туре:		Type:					
			Cancer					
Type: Type: Type:						Type:		
Contacts:								

Student Name:	Grade:	Date of Birth:						
FACTS CONCERNING STUDENT'S MEDICAL HISTORY continued								
Allergies:SeasonalBee StingAnimalsFood (list	threatening Allergies? Y	_Other (list N						
Allergy Testing: Date: Doctor's name:	3 3	Phone #:						
Reactions to medicine or injections? Y N (if Y explain)								
Hospitalized for serious illness, surgery, or accidents? Y N (if Y ex	 :plain)							
List any problems not identified above :								
List current medications (prescription, herbal, over-the-counter):								
 Parental/Guardian If for any reason, the above listed medical providers or hospital cann transport to be provided for my child to any appropriate medical care cover major surgery unless at least two licensed medical providers or impose liability on any school official or school employee who in good be financially responsible for all emergency care. 	ot be reached, I give permissi provider, hospital or medical oncur to the need. Nothing in	facility. This authorization does not this section shall be construed to						
Signature Parent/Guardian:		Date:						
 I, the undersigned as legal parent/guardian of my child's health between the school nurse (and designee) and the hinformation for mutual exchange of health/medical information for ediversity year only. 	nealth care providers listed ab ucational or emergency purpo	ove. This constitutes a release of oses of my child for the current school						
Signature Parent/Guardian:								
 I give permission for my child to participate in all school health screen nurse and/or administration with a separate written notification reque 								
Signature Parent/Guardian:		Date:						
School Nurse NOTES:								