SPRINGFIELD SCHOOL DISTRICT
STUDENT EMERGENCY MEDICAL CARD

STUDENT'S NAME_________________________ GRADE_____HR_____AGE_____DATE OF BIRTH__________

ADDRESS:____ HOME PHONE:__________________________

RESIDES W/ Parent 1______Parent 2______BOTH___GUARDIAN_____(NAME__________________________)

Parent 1 Name: ______________________________ Parent 2 Name: ______________________________

HOME PHONE:______________________________ HOME PHONE:______________________________

BUS. NAME/PHONE:______________________________ BUS. NAME/PHONE:______________________________

MOBILE PHONE/PAGER:______________________________ MOBILE PHONE/PAGER:______________________________

IF PARENT OR GUARDIAN CANNOT BE REACHED, CONTACT:

1. NAME:______________________________
   PHONE (H):______________(W)______________
2. NAME:______________________________
   PHONE (H):______________(W)______________

DOCTOR:____________________ DENTIST:____________________ ORTHODONTIST:____________________

PHONE:____________________ PHONE:____________________ PHONE:____________________

NAME/SCHOOL OF SIBLINGS ATTENDING SPRINGFIELD SCHOOL DISTRICT:______________________________

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PLEASE TURN OVER AND COMPLETE BOTH SIDES OF THIS CARD!!!!!!!

REVISED - JULY 2002
H-24 B

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1. **MEDICAL HISTORY**
   CHECK ANY MEDICAL CONDITION YOUR CHILD CURRENTLY HAS:
   ADD _____ADHD _____GASTROINTESTINAL _____ASTHMA_____
   USES INHALER_____CARDIOVASCULAR_____DIABETES_____
   ORTHOPEDIC_____FREQUENT HEADACHES_____MIGRAINES_____
   SEIZURE DISORDER_____OTHER______________________________

   ALLERGIES:
   FOOD______________________________
   DRUG______________________________
   INSECT______________________________
   ENVIRONMENTAL______________________________

2. LIST ANY MEDICATIONS YOUR CHILD TAKES. AT HOME: ______________AT SCHOOL:______________
   WHY?____
3. HAS HE/SHE BEEN HOSPITALIZED IN THE PAST YEAR? YES _____NO_____EXPLAIN____________________
4. THE SCHOOL NURSE OR DESIGNEE MAY ADMINISTER TYLENOL TO MY CHILD. YES_______NO_______
   THE SCHOOL NURSE OR DESIGNEE MAY ADMINISTER ANTACIDS TO MY CHILD. YES_______NO_______
   THE SCHOOL NURSE OR DESIGNEE MAY ADMINISTER IBUPROFEN TO MY CHILD. YES_______NO_______
5. I GIVE PERMISSION FOR MEDICATIONS TO BE ADMINISTERED BY SPSD PERSONNEL DURING FIELD TRIPS.
   YES______ NO______

AUTHORIZATION FOR EMERGENCY SERVICES TREATMENT OF MINOR

1. THE UNDERSIGNED IS THE PARENT /LEGAL GUARDIAN OF THE MINOR NAMED BELOW.
2. THIS AUTHORIZATION IS BEING PROVIDED FOR USE IN THE EMERGENCY TREATMENT OF THE MINOR NAMED BELOW WHEN NEITHER THE UNDERSIGNED, NOR RELATIVE/FRIEND IDENTIFIED (FRONT CARD) CAN BE REACHED TO PROVIDE CONSENT TO TREATMENT.
3. THE UNDERSIGNED AUTHORIZES PERSONNEL PERMISSION TO CARRY OUT ANY FIRST AID TREATMENT DEEMED NECESSARY FOR THE WELL BEING OF MY CHILD.
4. THE UNDERSIGNED GIVES PERMISSION FOR THE MINOR NAMED BELOW TO BE TAKEN TO A HOSPITAL OR DOCTOR FOR MEDICAL TREATMENT IN CASE OF ANY EMERGENCY.
5. THE UNDERSIGNED ASSUMES TRANSPORTATION RESPONSIBILITIES, IF THE MINOR NAMED BELOW NEEDS TO BE TAKEN TO A HOSPITAL, OR EMERGENCY FACILITY.

MINOR'S NAME:______________________________ HEALTH INSURANCE:______________________________

INSURED______________________________ POLICY NUMBER:__________________ ID NUMBER:__________________

SIGNATURE OF PARENT/GUARDIAN:____ **DATE:** ______________