The Foote School
EMERGENCY CONSENT AND INFORMATION FORM 2011-2012

STUDENT________________________________ BIRTHDATE_____________ GRADE ________

PARENT 1/GUARDIAN	PARENT 2/GUARDIAN
NAME____________________________	NAME____________________________
ADDRESS_________________________	ADDRESS_________________________
HOME PHONE ______________________	HOME PHONE ______________________
CELL PHONE ______________________	CELL PHONE ______________________
WORK PHONE______________________	WORK PHONE______________________
EMAIL____________________________	EMAIL____________________________

Child Lives With: ___ Both Parents ___Mother ___Father ___Other ____
Physician's Name: ___________________________Phone: _____________________*Is this different from Last Year?* _____
Dentist's Name: _____________________________Phone: _____________________*Is this different from Last Year?* _____
Health Insurance: ____________________________ID#: ____

EMERGENCY CONTACTS IF PARENTS CANNOT BE REACHED:
1. NAME _______________________________ PHONE _____________CELL _____________ RELATIONSHIP ___________
2. NAME _______________________________ PHONE _____________CELL _____________ RELATIONSHIP ___________

MEDICAL INFORMATION:
Does your child have allergies? ___ **Y**es/**N**o To What? ______________________________ Anaphylaxis? ____**Y**es/**N**o

Describe allergic reaction/treatment: ____Epi-Pen?______________

Any medical problems/conditions (i.e. asthma)____

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Any specific instructions/treatments: ____

Medications currently taken at home: ____

Will this be needed on field trips? ___ **Y**es/**N**o

Other medical information: ____

Any physical restrictions or accommodations requested: ____

THE SCHOOL NURSE MAY ADMINISTER TO MY CHILD THE FOLLOWING MEDICATIONS AS NEEDED:
__ ADVIL ___ TYLENOL __ BENADRYL __ TUMS __ COUGH DROP

CONSENT FOR MEDICAL TREATMENT:
I hereby give The Foote School the authority to obtain any necessary medical treatment for my child, if in the judgment of staff treatment is required. I give my permission to the school to release medical information to school staff/faculty and health care providers as necessary. I am aware that if my child self-carries an Epi-pen or inhaler to school it is my responsibility to make certain my child carries the medication to school each day and on all school related activities. I also give my permission to staff to administer medications in accordance with instructions provided by the school nurse or myself. In the event of an emergency, I also authorize the school activity chaperones to act on my behalf when seeking medical treatment. In the event I cannot be reached, I authorize medical treatment as deemed necessary by the attending physician or other health care provider.

I understand that I am financially responsible for any expenses for medical care or transportation incurred on my child's behalf.
Parent 1/Guardian Signature ____________________________ Date ________________________
Parent 2/Guardian Signature ____________________________ Date ________________________

Preferred Medical Facility
___ YNHN ___ St. Raphael ___ Yale Health ___ Other ____________________________