

Washington, D.C. Student Emergency Medical Form

Student's Name: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian Name(s) _____ / _____

Student Cell: _____ Parent Home: _____

Parent Cell: _____ Parent Cell: _____

Birthdate: _____ Height: _____ Weight: _____

Medical Information

Check any that you have had problems for which we should be aware. Please provide any necessary explanations.

_____ Asthma

_____ Diabetes

_____ Dizziness

_____ Sun Sensitivity

_____ Fear of Heights

_____ High BPH

_____ Claustrophobia

_____ Depression

_____ Motion Sickness

_____ Foot Trouble

_____ Ear Infections

_____ Hearing

_____ Headaches

_____ Upset Stomach

_____ Appendix

Removed

Explain (attached separate paper if necessary):

Check any allergies your child has, or has had in the past, and briefly describe reactions.

___ Insect Stings/Bites _____

___ Hay Fever _____

___ Food _____

___ Asthma _____

___ Seafood _____

___ Penicillin _____

___ Other _____

Does your child have any dietary considerations? If yes, please explain.

Medications

Complete the following chart with the information for ALL medications (prescription and non-prescription) that the student will need to take during the trip.

Medication	Dosage and Route to Admin	Frequency or Time(s) to Take	Reason for Medication	Possible Side Effects

I authorize the following child, _____, to receive the above medications as prescribed or needed.

Parent/Guardian Signature

Date

In the event of illness or accident, we will make every attempt to contact the parent/guardian and/or your family doctor.

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Email: _____