STUDENT CLINIC CARD

Stock # 90860
Revised 08/04/16

Grade _____

School_____ School Year_____

Teacher_____ Bus# _____

Student Name (Last, First):	Student ID:
Address:	Date of Birth

Parent / Legal Guardian Information

Mother's Name:	Father's Name:
Tel. #(home):	Tel.# Father (home):
Mother (work):	Father (work):
Mother (cell):	Father (cell):
Email Address:	Email Address:

Medical Information

Doctor's Name:	Doctor's Tel #:	Hospital Preference:

In the event the parent/guardian cannot be reached, the following are authorized to pick up my student

Name	Relationship	Telephone

I understand that in the event the parent/guardian cannot be reached, the school has my permission to take appropriate emergency action including calling 911. I understand it is also my responsibility to update the school as needed regarding any medical information which may impact my child during the school day.

_____

Signature of Parent / Legal Guardian

List any **MEDICATIONS** taken routinely and reason taken	
Medications	**Reason Taken**
Emergency Medications:	
CURRENT MEDICAL CONDITIONS that the school staff should be aware of (such as asthma, seizure disorder, diabetes, bleeding disorder, heart or stomach problems, mental health - ADD/ADHD, bipolar, anxiety, autism, etc.)	
Does your student need a HEALTH PLAN sent home for you to complete in order for this condition to be managed at school?	
☐ **No** ☐ **Yes** _____**INITIALS**	

List the **ALLERGIES** that your student has (such as food, insects, environmental, etc.):

Does your student need an allergy emergency plan for school?

☐ **No** ☐ **Yes** **_____INITIALS**

List others in your household attending G PS schools

Name	Relationship	School Attending

PLEASE FILL OUT MEDICAL INFORMATION ON REVERSE SIDE