

# EMERGENCY MEDICAL INFORMATION

Shadow Mountain Baptist School



Student Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Father: \_\_\_\_\_ Mother: \_\_\_\_\_  
Email: \_\_\_\_\_ Email: \_\_\_\_\_  
Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Home Phone # \_\_\_\_\_

My child may be given the following medication by Shadow Mountain Baptist School Personnel:

\_\_\_\_ Tylenol      \_\_\_\_ Ibuprofen      \_\_\_\_ Tums      \_\_\_\_ Pepto Bismol

Date of last tetanus shot: \_\_\_\_\_ Is your child presently taking any medication? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Is he/she allergic to any medication? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Is he/she allergic to bee stings? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Does he/she have any physical injuries, past or present? (Allergies, physical limitations, health conditions, etc.): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

If the doctors listed above cannot be reached, please take my child to the nearest emergency aid station, by ambulance if necessary, for treatment. I authorize Shadow Mountain Baptist School to seek emergency medical treatment on behalf of my child in the event of a sickness or injury at my expense. I authorize the release of my child from the emergency aid station to any SMBC or SMBS employee. I agree not to sue or hold SMBC or SMBS liable for any medical decisions made under emergency circumstances when I or my emergency contacts cannot be reached.

I authorize SMBS to release my child/children to the following: (LOCAL CONTACTS ONLY!)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Statement of Cooperation: I give permission for my child to take part in all school activities, including sports and school-sponsored trips away from the school premises, and absolve the school from liability to me or my child because of any injury to my child at school or during any school activity.