THE BIRCH SCHOOL

DATE ___/____/____

MEDICAL HISTORY AND EMERGENCY CONTACTS

To be completed by parent/guardian – PLEASE INITIAL in the areas requiring a YES or NO answer.

Child's Name: _____Date of Birth: _____Age_____
Home Phone:_____Alt Phone: _____
Address: _____
Has your child ever had? Chicken Pox _____ Pneumonia _____
Is your child subject to or ever been treated for: Fainting spells _____ Headaches _____ Allergies____
Tonsilitis _____ Abdominal Pain _____ Fracture _____ Concussion _____ Hernia _____
If yes, please explain: _____
_____
Is your child prone to: Ear Infections _____ Sinus Infections _____ Lung/Kidney Disorder _____
Has your child been treated for any difficulties relating to the heart? _____
Is your child allergic to any drugs: Penicillin/Sulfur/Other:_____
Does your child have any allergies? (Bee stings, pollen, hay, food, etc.) if yes please be specific.
_____
Has your child been stung by a bee or wasp? _____ If Yes, what was his/her physical reaction?
_____
Do you grant permission to administer Benadryl <u>if necessary</u> following an insect sting? Yes ___ No __
Do you grant permission for your child to use natural bug repellant when needed? Yes ___ No ___
Does your child have asthma? Yes _____ No _____ Use inhaler or Nebulizer?_____
Is your child currently taking any medication? _____ If yes, what is the medication?
_____
If your child is taking medication during the day, please send a note from your physician to authorize Director to store and distribute the medication during the day. Medication should be in original prescription bottle or container only.

Any restrictions for physical activity? _____

Any other concerns, or information that you feel would help us be responsive to your child's needs?
_____
_____
_____
_____

EMERGENCY CONTACTS DURING PROGRAM HOURS

Primary Contact:	Second Contact:	Third Contact:
_____	_____	_____
Relationship:	Relationship:	Relationship:
_____	_____	_____
Phone: _____	Phone:_____	Phone:_____
Alt Phone:_____	Alt Phone:_____	Alt Phone:_____

PHYSICIAN NAME: _____ PHONE NUMBER:_____
Insurance ID Information: _____

I understand that my signature here indicates that the above information is complete and correct. I also give permission, in case of injury,for Birch School personnel to administer First Aid/treatment when the need for such treatment is immediate, and efforts to contact above are unsuccessful. I also authorize the Director to take my child to the hospital for treatment if necessary. I further authorize Director to discuss any medical conditions with school staff, in his/her sole discretion, believes such communication to be in the best interest of the child.

Signature:_____ Date: _____