Springfield Public Schools
Care of Emergency, Illness, or Accident

Dear Parent/Guardian:

In order that we may care for your child in case of illness or accident in accordance with your wishes, please complete the information below and return this form to your school nurse.

Name of Student_____Birth Date_____Grade_____
Home Address_____Phone &/or Cell #_____
Mother_____Phone &/or Cell #_____
Father_____ Phone &/or Cell #_____
Guardian_____Phone &/or Cell #_____

If a parent or guardian cannot be reached in an emergency, please list the names of responsible adults to call who may pick up your child:

Name_____Phone &/or Cell #_____
Name_____Phone &/or Cell#_____

If a serious illness or accident occurs at school, please call my child's physician/nurse practitioner at:
MD/NP_____Phone #_____
I understand the school will try to contact the parent/guardian before calling the doctor. In the event that my doctor cannot be located, permission is given to the school to call the school doctor/NP and/or take my child to a hospital for treatment, by ambulance if necessary.

Insurance Carrier:_____Insurance Policy #_____

I give permission to the school nurse to administer the following meds: (**Please check all that apply or "ALL")**

____ Acetaminophen (Tylenol) ____ Ibuprofen (Motrin) (**for menstrual cramps only**) ____ Calcium Carbonate (TUMS) **(for grades 9-12 only)**
____ Benadryl ____Calamine Lotion ____ Antibiotic Ointment

____All of the Above ____None of the Above

Please list all medications that your child takes:_____.

Please check all that applies to your child:

□ ADD/ADHD □ Asthma □ Depression □ Diabetes □Heart Condition □ Seizure Disorder □Migraines
□Other (Specify):_____
□Allergies: ie: food, insect, medication, environment (Specify):_____
_____
□ A significant illness or injury in the past 12 months
(Specify):_____
_____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

Signature:_____Date:_____

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