

Medical Information

Child's Name: _____ Grade: _____

My child is **Allergic** to: _____

Indicate any pertinent **Health/Medical Problems**: _____

Medications routinely taken: _____

List Brothers and Sisters: _____ Grade: _____

_____ Grade: _____

_____ Grade: _____

_____ Grade: _____

_____ Grade: _____

Name of Family Doctor: _____ Phone: _____

Pager #: _____ Hospital Doctor uses: _____

Name of Family Dentist: _____ Phone: _____

In the event of an emergency, I give Springs Valley School permission to obtain medical assistance (doctor or ambulance). The school will attempt to contact parents first. In addition, I give permission for the release of the above information to school employees and bus drivers.

Parent/Guardian Signature: _____ **Date:** _____