EMERGENCY INFORMATION CARD
and AUTHORIZATION FOR MEDICAL TREATMENT

Students's Name ______________________________

Mailing Address ______________ (Street) ______________ (City) ______________ (State)

911 Address ______________ (Street) ______________ (City) ______________ (State)

Mother: ______________ (Mother / Stepmother)

Mother's Work Phone No. ______________

Father: ______________ (Father / Stepfather)

Father's Work Phone No. ______________

Teacher: ______________

Grade: ______________ Bus No. ______________

Student's Birthdate: ______________

Home Phone No. : ______________

Mother's Cell Phone #: ______________

Father's Cell Phone #: ______________

Student's Cell Phone #: ______________

Student Resides with: ______________

❑ Documents on File ❑ Provisional

❑ Court Appointed Legal Guardian

Other Emergency Phone Numbers: (Please list at least 3 people)

Name: ______________ (Relative / Friend) Phone: ______________ ID: ______________

Name: ______________ (Relative / Friend) Phone: ______________ ID: ______________

Name: ______________ (Relative / Friend) Phone: ______________ ID: ______________

Only persons listed above with proper identification can check the student out of school and/or administer medications. Other persons must have written permission and proper identification to check the student out of school.

In case of an accident or serious illness, I hereby authorize school officials to make whatever arrangements seem necessary and to contact me immediately. I understand that it remains my responsibility to make any further changes on this medical card, as the need arises, by contacting the school. Otherwise, this authorization will remain in effect as it appears on this date.

SIGNATURE OF PARENT / LEGAL GUARDIAN: ______________ Date: ______________

Note: The signature of the parent or legal guardian denotes permission for a school official to permit this student to leave school with any of the above named, after adequate identification is presented and written permission is presented.

Beauregard Parish School Board does not assume responsibility for medical charges

Please complete the other side

MEDICAL INFORMATION:

(Check only if condition present or recurring.)

- ❑ **ADD / ADHD**
- ❑ **Allergy** Type:
  Degree: ❑ Seasonal ❑ Mild ❑ Moderate ❑ Severe
- ❑ **Asthma:** Number of Episodes/Year
  ❑ 0 - 1 ❑ 2 - 4 ❑ 5 - 8 ❑ 8 - 12 ❑ 13+
- ❑ **Blood Disorders**
- ❑ **Diabetes:** ❑ Non-insulin Dependent ❑ Insulin Dependent
- ❑ **Hearing Deficit** (hearing loss / hearing aids)
- ❑ **Heart Condition**
- ❑ **Hemophiliac**
- ❑ **Other:** ______________
- ❑ **Neurological / Muscular Disorders**
- ❑ **Seizures** ❑ Grand Mal ❑ Petit Mal ❑ Other: ______________
  How frequent? ______________ Last Seizure: ______________
  Medication(s)? ______________
  Medication(s) at school? ______________
- ❑ **Sickle Cell Anemia**
- ❑ **Vision Deficit(s):** ______________

Explain any medical condition checked

____

Does the student take any medication(s) at home?

Please List: ______________

Is medication to be administered at school?

❑ No ❑ Yes Name of Medication / Type / Time:

____

Physician Name / Phone: ______________

The Beauregard Parish School Board is an equal opportunity agency dedicated to a policy of nondiscrimination regarding Title VI, The Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973.

K & S Ink – (337) 460-2057