



## 2009-2010 Resident Student Emergency/Medical Information

This form will be made available to school personnel and coaches. All confidential medical information should be listed on the Medication Consent form. **Please use black or blue ink.**

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
mm/dd/yyyy

Home Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

### Alternate Emergency Contacts

1. Houseparents: \_\_\_\_\_ 2. Name/Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone : (\_\_\_\_) \_\_\_\_\_

Work/Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work/Cell Phone: (\_\_\_\_) \_\_\_\_\_

### Medical Information

List any **allergies** (to food, insect stings, latex, medication, other): \_\_\_\_\_

**\*NOTE:** If your student has a life threatening allergy (e.g. bee stings), be certain that the school is provided with an emergency kit.

List all current **prescription medications** (including inhalers): \_\_\_\_\_

Prescription medications (such as Ritalin, Adderall, antibiotics, etc.) will be dispensed by school personnel only when the medication is in the original prescription container with clear instructions. **Students may not carry medications except Epi-pens, insulin, and asthma rescue inhalers.**

List current and/or chronic **health conditions** (such as ADD, ADHD, asthma, depression, diabetes, heart problems, migraine headaches, seizure disorders, etc.): \_\_\_\_\_

### Authorization for Medical Treatment

In the event of an illness or accident, I hereby authorize Ben Lippen School to act on my behalf for the student named above in the securing of medical, surgical, and/or dental treatment. In the event of an emergency, I hereby give my permission to the physician selected by Ben Lippen School to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for the student named above. **If such an event occurs, I understand that every effort will be made to contact me as soon as possible.** I certify that I am the parent/guardian or have the legal ability to sign these authorizations on behalf of the student named above. I understand I am responsible for all expenses that the insurance does not pay.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date