Rio Rancho Public Schools
S.A.F.E. Before and After School Program
Medical Information Form

School Year 2009-2010

Student Name: _____ **DOB:** _____/_____/_____ **Grade:** _____

Please indicate if student has had or is currently under treatment for any of the following conditions (provide year or age when problem occurred):

- ❑ Allergies (check all that apply)
  ❑Seasonal ❑Food ❑Bee Sting
  ❑Animals ❑Other _____
- ❑ Arthritis
- ❑ Asthma
- ❑ ADD/ADHD
- ❑ Diabetes
- ❑ Ear/Hearing
- ❑ Mental Health
- ❑ Seizure
- ❑ Heart Problem (type)_____
- ❑ Hepatitis (type)_____
- ❑ Hospitalized for serious illness, surgery or accidents
- ❑ Meningitis
- ❑ Migraine Headaches
- ❑ Muscular Weakness or Paralysis
- ❑ Bleeding Disorders
- ❑ High Blood Pressure
- ❑ Infectious Diseases
- ❑ Substance Abuse
- ❑ Reactions to Medications or Injections
- ❑ Need antibiotic therapy before dental treatment. Why?_____
- ❑ Long Term Medications, please list_____
- ❑ Other health conditions not listed_____

❑ **My child has no known health conditions**

Emergency Contact Information other than parent or guardian:

Name	Relationship	Phone #1	Phone #2

Insurance Information:

_____

Students Insurance (primary) Subscribers Name ID#

In case of an emergency involving my child AND I CANNOT BE REACHED, I hereby give consent to transport my child to the following medical care providers/hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Physician/Nurse Practitioner or Physician Assistant _____Phone #_____

Dentist _____Phone #_____Hospital _____Phone #_____

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CAN BE REACHED, I authorize appropriate transport and medical care of my child to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with the section. It is understood that I will be financial responsibly for all emergency care.

I authorize the Safe Schools staff to contact my child's providers listed above regarding medical management of my child. I understand information on this form will be shared with appropriate personnel on an as=needed basis only.

Signature of Parent/Guardian_____**Date**_____

Revised 03/08