

Martin County Schools Student Emergency Card

Grade _____ Homeroom _____ Year _____

Student Name _____ Gender: M F Age: _____

Address _____ City _____ DOB _____

Parent/Guardian _____ Home phone _____
 _____ Work phone _____
 _____ Other phone _____

Emergency Contact _____ Phone _____

Emergency Contact _____ Phone _____

Doctor _____ Phone _____

Hospital Preference _____

Serious Health Condition _____

IMPORTANT MEDICAL INFORMATION

Please provide your medical history by checking the column that indicates any medical information that pertains to you. List any medications taken daily or medications needed in a medical emergency. Please specify if medications are taken at school. The proper authorization form must be completed.

Medical Condition	Yes	No	Prescribed Medication
Asthma			
*Allergies (list)			
*Allergic Reaction			
Diabetes			
Seizures			
Sickle Cell Disease			
Bleeding Disorders			
Heart Problems			
Hearing Problems			
Vision Problems			
Orthopedic Problems			
Other:			
Other:			

*Allergies _____

*Describe Allergic Reactions (bee stings, etc.) _____

In case of a medical emergency, injury or serious illness, I hereby authorize school personnel to take or send my child to the family physician or the hospital.

Parent/Guardian's Signature

Date