## STUDENT CONTACT INFORMATION SHEET

SCHOOL YEAR \_\_\_\_\_

STUDENT NAME

PARENTS' NAME(S)	
MAILING ADDRESS	
STREET ADDRESS	
HOME PHONE	

DAD'S WORK	PHONE:
MOM'S WORK	PHONE:

EMERGENCY CONTACT		PHONE:
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## **MEDICAL INFORMATION – EMERGENCY TREATMENT**

Occasionally we have students who come to the Nurse's Office during school hours with complaints of illness or injury. According to School District Policy and under guidelines by Arizona Department of Health Services, the District is required to have written parent/guardian permission to administer **any type** of medication. This includes both over-the-counter and prescription medication.

Please complete the following to authorize the Nurse's Office to administer Tylenol, antibiotic ointment or cough drops when indicated to your child. Also, complete the following in order to permit school personnel to seek emergency medical treatment for your child in the event of a medical emergency.

STUDENT NAME:	DOB:	GRADE:

CURRENT MEDICAL CONDITION:

KNOWN MEDICAL ALLERGIES (Please List):

Family Physician

Phone