BALDWINSVILLE CENTRAL SCHOOL DISTRICT
MEDICAL INFORMATION

Student Name: _____

Home Address: _____
(Street)

_____
(Town/Village) (Zip Code)

Phone Number: _____

Family Physician: _____ Phone Number: _____

Insurance Company: _____ Insurance Policy Number: _____

Employer: _____

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Allergies: _____

Currently on a daily medication: NO _____ YES _____ Medication: _____

Currently on as needed medication – inhaler, epi-pen, glucagon, etc. NO _____ YES _____

Name of Medication: _____

Any medical needs – glucose monitoring, seizure evaluation, etc. NO _____ YES _____

Explain medical need: _____

If you answered yes to any of the above questions, please contact the teacher ASAP.

MEDICAL AUTHORIZATION

In case of an emergency, representatives of the Baldwinsville Central School District are hereby authorized to arrange for medical, dental, health and/or hospital services for the above named student. This authorization includes transportation to an emergency for, first aid, treatment, and other action deemed necessary by the school district, representative, physician, medical staff, or dentist. I understand that the school district cannot assume responsibility for the payment of medical fees or expenses incurred, and I hereby release and hold the school district harmless from any claim for medical fees or expenses and any related costs or damages.

_____ _____
Signature of Parent/Guardian Date

Rev. 3/04