Lisbon School Department
Student Health/Emergency Information

Student Name:	Date of birth:	Grade/Teacher:
Address:		Phone:
Resides with:	Relationship to student:	

Mother's/Guardian's Name/:	Home Phone:	Work Phone:	Cell:
Father's/Guardian's Name:	Home Phone:	Work Phone:	Cell:

In case of emergency/illness and we are unable to reach family members listed above, who may we contact for medical care or dismissal?

#1 contact:	Phone:
#2 contact:	Phone:

Primary Doctor:	Phone:
Dentist:	Phone:

Date of child's last physical-_____, Date of child's last eye exam-_____

Allergies requiring treatment: ☐ Food ☐ Medications ☐ Insects ☐ Other	
Allergy Name:	Reactions:
Treatment Plan:	

Check medical conditions requiring treatment.

☐ Asthma ☐ Frequent headaches ☐ Heart disease ☐ Diabetes
☐ Seizures ☐ Contacts/glasses ☐ Menstrual issue ☐ ADD/ADHD
☐ Hearing problems ☐ Kidney disease ☐ Dizziness/fainting
☐ Other _____

Describe your child's symptoms and the treatment and/or medications required for the conditions you checked above.

Please note any medication that your child takes including dose:

My child has my permission to receive health/wellness and support services. In case of accident or serious illness, I authorize the school to transport my child to appropriate medical care or call the nearest ambulance if I am unable to be reached. This information will only be shared with appropriate school personnel in order to meet my child's safety and health care needs. I give permission to exchange information with my child's physician for the purpose of referral, diagnosis and treatment. It is my responsibility to notify the school of changes in this information.

Parent/Guardian Signature _____Date

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