FAIRFIELD SCHOOL DISTRICT EMERGENCY INFORMATION

6th Grade Camp

Student Name *(Last, First, Middle)*	ID #	Grade	DOB
Address (Street, City, State, Zip)			
Parent/Guardian Email Address – (must be filled out for on-line grade book/email agreement)			
Student lives with: (F=Father, M=Mother, B=Both, O=Other F/S=Father & Stepmother, M/S=Mother & Stepfather G=Guardian ☐			Home Phone

FIRST PARENT (You must list a **Resident Parent/Guardian** that the student **lives** with)

Resident Parent/Guardian Name	Cell Phone	
Employer	Work Phone	Ext.
OTHER ADULT in HOUSEHOLD	Cell Phone	
Employer	Work Phone	Ext.

In case of an emergency, parents will be contacted first. If parents cannot be reached, contact:

Contact Person	**Relationship**	**Telephone**
#1		
#2		

SECOND PARENT (For use **only** when listing a parent that the student **does not** reside with, but will receive information)

Parent/Guardian Name			
Address (Street, City, State, Zip)			
Home Phone	Cell Phone	Work Phone	Ext.

Physician's Name	Telephone
May we contact your physician if necessary? ☐ Yes ☐ No	

Please complete both sides of form

Updated 3/1/11

MEDICAL HISTORY (Your child's medical condition will be shared with necessary school personnel unless otherwise indicated). Please check any medical condition that pertains to your child and provide an explanation.

Condition	Yes	Comments	Condition	Yes	Comments
Allergy:			Cardiovascular		
Bee Sting			Diabetes		
Drug			Gastrointestinal		
Food			Hearing Disorder /Deafness		
Latex			Migraines		
Peanut			Orthopedic Disorder		
Seasonal			Seizure Disorder		
Tree Nut			Vision Disorder		
Asthma			Other		
ADD/ADHD					

Additional Information**:**

_____

_____

MEDICATIONS TAKEN AT HOME:

Please list the name and reason for any medication, *prescribed or over-the-counter*, that your child is receiving on a regular basis.

Name	Reason	Dose	Times

OVER-THE-COUNTER-MEDICATIONS AVAILABLE AT SCHOOL/CAMP per School Physician Order: Please note that any medication/s *NOT* on this list will require a physician's order to be given at school/camp.

My child may be given (please initial medications you authorize):

Medication	Initial	Dose
Antacid	_____	_____
Benadryl	_____	_____
Ibuprofen (Advil)	_____	_____
Acetaminophen (Tylenol)	_____	_____

If you do not indicate a dose, it will be administered according to the student's age/weight.

Does your child walk in his/her sleep? Yes_____ No_____

Parent/Guardians release the Fairfield Area School District, its officers, agents, and employees from all claims and liabilities of any kind arising out of the dispensing of medication to the student pursuant to the authorization granted herein.

In the event of an emergency which would require medical care and treatment to be administered to the student, I/we hereby authorize any physician, hospital, or other health care provider to give emergency medical care and treatment to this student.

The undersigned have read this Medical Authorization Consent Form and declare and affirm that I/we agree to the consents herein stated.

_____

Parent/Guardian – Please Print Signature Date

_____

Parent/Guardian – Please Print Signature Date

_____

Student's Signature (only if student is 18 or older) Date