Medical/Dental Information

Allergy/Medical Condition_____

☐ Is this condition critical information that the staff should be alerted to?

Physician Name_____ Physician Phone Number_____

Dentist Name_____Dentist Phone Number_____

Insurance_____ Insurance Policy Number_____

Permission for Screenings:

My child has permission to be screened for vision, hearing, speech, language, motor, physical, and mental development under the direction of Johnson County School System. All information will be held in accordance with Confidentiality Law (P.L. 93-308 Sec. 513, Rights and Privacy of Parent and Students Act of 1974).

Signature of Parent/Guardian_____Date_____

Emergency Medical Release:

In case of accident or illness, school personnel have my permission to transport my child to his/her home, the family doctor's office, or the nearest emergency room. The attending physician has our permission to treat our child, administering the medical service available.

Signature of Parent/Guardian_____Date_____

Emergency Contact Information

Primary Emergency Contact:

Name_____Contact Home Phone_____

Contact Work Phone_____ Contact Cell Phone_____

Relationship to Child_____

Secondary Emergency Contact:

Name_____ Contact Home Phone_____

Contact Work Phone_____ Contact Cell Phone_____

List of people that may pick my child up from school (include name and telephone number):

_____ _____

_____ _____

_____ _____

_____ _____