MEDICAL ASSISTANCE CARD

CROMWELL PUBLIC SCHOOLS

Specify any health problems such as Allergies, Diabetes, Epilepsy, Medications

_____

_____

Child's name _____
last name first name

Address _____

Date of birth _____ Place of birth _____

Grade _____ Teacher _____

Please fill out and return to school. This will be kept on file as a permanent record to know whom to contact in case of an emergency. Please notify the school immediately in writing of any change.

Father or Guardian Name: _____ Home phone (_____)_____

Address _____ Work phone (_____)_____

Email Address _____ Cell phone (_____)_____

Mother or Guardian Name: _____ Home phone (_____)_____

Address _____ Work phone (_____)_____

Email Address _____ Cell phone (_____)_____

If above cannot be located call:

Name _____ phone (_____)_____

2nd choice _____ phone (_____)_____

Family physician _____ phone (_____)_____

- In the event your child needs to be transported via ambulance, your preferred hospital would be _____ if EMS policies/procedures allow.
- In case of illness, the transportation is the parent's/guardian's responsibility. Please plan arrangements with a relative, neighbor or friend ahead of time, in case you are unable to transport your child home.
- Student will be treated according to the standing orders of the school physician.
- Student will be added to a confidential health problems list for school personnel only, if diagnosed with a medical condition.
- Does your child have health insurance? yes no

Date _____ Signature _____