

**EMERGENCY MEDICAL INFORMATION (Mail in)**  
**BROOKLINE SUMMER SCHOOL 2017**

**Student:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Grade entering in Sept: \_\_\_\_\_ School: \_\_\_\_\_

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Work or Cell phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Work or Cell phone: \_\_\_\_\_

Pediatrician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency contact if parent/guardian is not available:**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health Information**

Does your child have an allergy to **food, bee stings, or insects**? \_\_\_ yes \_\_\_ no

If yes, what is the allergen?

Does your child use an Epi-Pen? \_\_\_ yes \_\_\_ no Treatment?

Does your child have any **other allergies** (aspirin, etc.)? \_\_\_ yes \_\_\_ no

If yes, what is the allergen?

Treatment?

Does your child have any medical concerns? \_\_\_ yes \_\_\_ no

If yes, please state the diagnosis:

Does your child take medications? \_\_\_ yes \_\_\_ no

If yes, please list the medications:

Are there any factors that make it advisable for your child to follow a program of limited physical activities?

\_\_\_ yes \_\_\_ no If yes, please specify the limitations:

Health Insurance Provider: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Policy # \_\_\_\_\_

We will contact parents/guardians in case of serious illness or accident. However, in the event of an emergency situation that requires immediate medical attention I, \_\_\_\_\_, hereby give permission to the physician selected by the Director or the Trip Leader to hospitalize, secure proper treatment for, order injection, anesthesia, or surgery for my child as named above.

**Signed:** \_\_\_\_\_ **Relationship to child** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Public Schools of Brookline*