Emergency Information

The information that you provide is confidential and will only be used in the event of sudden illness or injury that requires emergency treatment.

Name:_____ **Date of Birth:**_____

Address:_____ **Phone:**_____

1. **Emergency Contact (Call First)**
   Name/Relationship:_____
   Phone Number(s):_____
2. **Emergency Contact (Call Second)**
   Name/Relationship:_____
   Phone Number(s):_____

Hospital of Choice:_____

Physician's Name:_____ **Phone**_____

Dentist's Name:_____ **Phone**_____

Allergies (medications/food/insects/other):_____

_____

Chronic Conditions/Illnesses/Surgeries:_____

_____

Current Medications (Prescriptions and/or Over-The-Counter):_____

_____

Special Instructions:_____

The above information may be released to emergency responders, the receiving hospital and the designated emergency contacts.

Signature_____ **Date**_____

Authorization to Administer Medication

I hereby authorize Freeburg Community High School and its employees and agents, on my behalf and stead, to administer lawfully prescribed and/or non-prescription medication to my child. I acknowledge that it may be necessary for the administration of medication to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when medication is administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempt to administer medication.

Signature_____ **Date**_____

Special Instructions_____

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