ROCK BROOK SCHOOL 2021-2022 MEDICAL INFORMATION FORM

*ALL FIELDS ARE REQUIRED

Student's Name: _____ **Student's Date of Birth:** _____

Home Address: _____

STREET CITY STATE ZIP

Mother's Name: _____ **Telephone # (___)** _____

Father's Name: _____ **Telephone # (___)** _____

Student's Physician: _____ **Telephone # (___)** _____

Physician's Address: _____

STREET CITY STATE ZIP

Health Insurance Carrier: _____ **ID #:** _____

Group #: _____

EMERGENCY CONTACTS:

1. **Name:** _____ **Relationship to student:** _____

   Telephone # (___) _____

2. **Name:** _____ **Relationship to student:** _____

   Telephone # (___) _____

Does your student have any allergies? (YES / NO)
Please list any allergies if any: _____

Any medical conditions that would restrict your student's participation in any activities? (YES / NO)

If yes, please explain: _____

Other conditions the school nurse should be aware of? _____

PARENT/LEGAL GUARDIAN AUTHORIZATION I realize there is a risk of being injured that is inherent in all activities. To the best of my knowledge, the information recorded above is correct and complete. I give my permission for my child to participate in all activities involved in this program. In the event that I cannot be reached in an emergency, accident or injury, which occurs while this student is attending Rock Brook School, I hereby give my permission for the adult representative of Rock Brook School to secure whatever medical or hospital care that may be necessary and agree to be financially responsible for such care. I further hold Rock Brook School and its representatives harmless from and indemnify them against any liability or loss incurred in connection with any injury to or as a result of any treatment rendered pursuant to the permission to participate for the student above.

Parent/Guardian Signature: _____ **Date:** _____