

# CENTREVILLE LAYTON SCHOOL EMERGENCY AND MEDICAL INFORMATION CARD 2025-2026

*This information may be shared with Centreville Layton Staff only*

**STUDENT NAME:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of last physical examination:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ **Phone: (** \_\_\_\_\_ **)** \_\_\_\_\_

**Child's Psychiatrist (if applicable):** \_\_\_\_\_ **Phone: (** \_\_\_\_\_ **)** \_\_\_\_\_

1. PLEASE CHECK IF YOUR CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Dental	<input type="checkbox"/> Fainting	<input type="checkbox"/> Infections	<input type="checkbox"/> Seizures
<input type="checkbox"/> Autism Spectrum Dis.	<input type="checkbox"/> Bone/Spine	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing	<input type="checkbox"/> Kidney	<input type="checkbox"/> Speech
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowel/Bladder	<input type="checkbox"/> Emotional	<input type="checkbox"/> Heart	<input type="checkbox"/> Menstruation	<input type="checkbox"/> Vision
<input type="checkbox"/> Behavior	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Headaches	<input type="checkbox"/> Physical Disabilities	
<input type="checkbox"/> Other _____					

Comments: \_\_\_\_\_

2. Does your child have any allergies? ☐ None ☐ Medication ☐ Seasonal ☐ Insects ☐ Food ☐ Latex ☐ Other \_\_\_\_\_

Please specify the allergy and the reaction: \_\_\_\_\_

Indicate treatment for allergies (**Attach the Allergy/Anaphylaxis Action Plan from the physician**): \_\_\_\_\_

3. Has your child had any illness since school ended in June? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain \_\_\_\_\_

4. Has your child had any surgery since school ended in June? Yes \_\_\_\_\_ No \_\_\_\_\_

Type of surgery, with date(s) \_\_\_\_\_

5. Please attach a copy of the updated immunization record to this form (including COVID-19).

6. List all your child's medications and treatments including name, dosage, frequency and reason: \_\_\_\_\_

7. Does your child wear glasses or contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last prescription: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

8. Check next to the following to give permission for the school nurse or authorized school personnel to administer :

\_\_\_ **All of the below**

\_\_\_ **None, please call first**

\_\_\_ Benadryl

\_\_\_ Tums

\_\_\_ Acetaminophen (Tylenol)

\_\_\_ Cough drops/throat lozenges

\_\_\_ Eye drops (Visine/lubricating drops)

\_\_\_ First aid antibiotic ointment

\_\_\_ Ibuprofen (Motrin)

\_\_\_ Topical (Benadryl/Clear Itch/Hydrocortisone 1%)

\_\_\_ Oral anesthetic (Oragel)

The Parent/Guardian(s) will be contacted for any child who is seen, evaluated and/or treated in the nurse's office. If it is not an emergency, the nurse will send an email to the email address on file. If we need to speak with you immediately, we will call the emergency numbers listed for the parent/guardian(s) until we get human voice contact.

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Email #1: \_\_\_\_\_ Email #2: \_\_\_\_\_

**MOTHER/GUARDIAN:** \_\_\_\_\_ Employer: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**FATHER/GUARDIAN:** \_\_\_\_\_ Employer: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**EMERGENCY CONTACTS:** *If Parents/Guardians cannot be reached, please call.*

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Has your child had any emotional upset since school ended in June? (deaths, divorces, separations, recent moves, etc.) Please explain:

\_\_\_\_\_  
\_\_\_\_\_

Additional information Centreville Layton School should know: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL INSURANCE INFORMATION:**

Insurance Provider: \_\_\_\_\_ Student's Insurance I.D.# \_\_\_\_\_

Hospital of Preference: \_\_\_\_\_

**SCHOOL MEDICAL EMERGENCY PROCEDURES:** Centreville Layton School has adopted the following procedures in caring for your child when he/she becomes sick or injured at school. In case of emergency and/or need of medical care:

1. The school will call parent/guardian cell phone numbers first. If there is no answer,
2. The school will call the parent/guardian home phone and work phone numbers. If there is no answer,
3. The school will call the emergency contacts.
4. If none of the above answer, the school will call an ambulance, if necessary, to transport the child to a local medical facility.
5. Based upon the medical judgment of the attending physician, the child may be admitted to a local medical facility.
6. The school will continue to call the parents, guardians or emergency contacts until someone is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for transporting and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the admission of anesthesia which may be carried out based on the medical judgment of the attending physician.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_