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| GCPS Logo | **STUDENT CLINIC CARD** **Shiloh High School 2012-13**  | Teacher:  Student Cell: |

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| Student Name (Last, First Middle):  | Student ID:  |
| Address:  | Date of Birth |
| **Parent / Legal Guardian Information** |
| Parent:  | Parent 2:  |
| Tel. #(home):  | Tel. #:  |
| Work Phone:  | Work Phone:  |
| Cell Phone:  | Cell Phone:  |
| Email Address:  | Email Address:  |
| **Medical Information** |
| Physician:  | Phone:  | Hospital Preference: |
| In the event the parent/guardian cannot be reached, the following are authorized to pick up my student |
| **Name** | **Relationship** | **Telephone** |
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| I understand that in the event the parent/guardian cannot be reached, the school has my permission to take appropriate emergency action including calling 911. I understand it is also my responsibility to update the school as needed regarding any medical information which may impact my child during the school day. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent / Legal Guardian Date |

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| List any **MEDICATIONS** taken routinely and reason taken |
| **Medications** | **Reason Taken** |
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| **Emergency Medications:** |  |

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| CURRENT MEDICAL CONDITIONS that the school staff should be aware of (such as asthma, seizure disorder, diabetes, bleeding disorder, heart or stomach problems, etc) |
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| If you listed a medical condition above, will your child require a detailed medical treatment plan for this condition? |
| **[ ]  No [ ]  Yes** \_\_\_\_\_\_\_\_**INITIALS** |

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| List the **ALLERGIES** that your student has (such as food, insects, environmental, etc.): |
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| Does your student need an allergy emergency plan for school? |
|  **[ ]  No [ ]  Yes \_\_\_\_\_\_\_INITIALS** |

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| **List others in your household attending GCPS schools** |
| **Name** | **Relationship** | **School Attending** |
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