SCURRY-ROSSER INDEPENDENT SCHOOL DISTRICT

Student Medical / Emergency Information Card

Student's Name _____ Date _____

Address _____ Birth Date_____ Sex:_____

TO PARENT OR GUARDIAN: To serve your child in case of accident or illness, please furnish the following information:

Father's Name _____ Father's Home Phone# _____

Cell Phone # _____ Work Phone # _____

Mother's Name _____ Mother's Home Phone # _____

Cell Phone # _____ Work Phone # _____

List two persons who will assume temporary care of your child if you cannot be contacted.

Name _____ Phone # _____

Name _____ Phone # _____

Doctor _____ Phone # _____

Dentist _____ Phone # _____

Guarantor's _____

INSURANCE COMPANY PHONE # NAME OF INSURED

EMPLOYER GROUP# INDIVIDUAL POLICY #

I, the undersigned, do hereby authorize employees of Scurry-Rosser Independent School District to contact directly the persons and health care providers named on this card, and do authorize the named physicians, clinics, and/or hospitals to render such treatment as may be deemed necessary for the transportation and health care of said child. In the event the physicians, other persons named on this card, or parents cannot be contacted, the school employees are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. (Section 35.01, Texas Family Code) I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

I request that the physicians, dentists and staff of the medical facility perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatments and anesthetics as may be necessary in the diagnosis and treatment of my child. I understand that I must notify Scurry-Rosser I.S.D. in writing to change any information on this form or to revoke any consent given herein. I testify all information on this document to be true and correct.

If a valid notary signature appears below, a copy of this document should be considered as valid as the original. Original forms are on file in the SRISD athletic office and available for inspection upon request.

I do _____ or do not _____ carry insurance on _____

Athlete's Name

OVER THE COUNTER MEDICATION APPROVAL

The following Over the Counter (OTC) medications are provided for your student/athlete **ONLY** with your permission. Please indicate with a **CHECK** any medicines you wish to be **WITHELD** from your child.

____ Alcalak (Antacid) ____ Diotame (Pepto Bismol)

____ Ibuprofen (Advil) ____ APAP (Tylenol)

____ Diamode (Imodium AD) ____ Medikoff Drop (cough drops)

____ Diphen (Benadryl) *Only given in case of severe allergic reaction*

Prescription Medications Currently Taking: _____

Allergic Reactions to Medications: _____

THIS FORM MUST BE SIGNED IN FRONT OF A NOTARY PUBLIC BEFORE TURNING INTO THE SCHOOL

PRINTED NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

STATE OF TEXAS, COUNTY OF _____ SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____ DAY OF _____ A.D _____.

_____

Notary Public Signature