



# The Brookwood School

## Medical Emergency and Safe Release Information

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

First Name

M.I.

Last Name

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Program Entering: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

e-mail \_\_\_\_\_

Phone: Home # \_\_\_\_\_

Work # \_\_\_\_\_

Cell # \_\_\_\_\_

e-mail \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

### If parents are unavailable in an emergency, contact:

Name and Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

Name and Relationship: \_\_\_\_\_ Phone \_\_\_\_\_

Please list the names of those who will be picking up your child. Your child will not be released to anyone other than those listed, unless we have a dated and signed note from a parent or guardian. Please remember that anyone not regularly picking up your child must have photo identification.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Please circle all that apply and add specific information:

Allergies: Yes No \_\_\_\_\_

Asthma Yes No \_\_\_\_\_

Seizures: Yes No \_\_\_\_\_

Vision Problems: Yes No \_\_\_\_\_

Hearing Problems: Yes No \_\_\_\_\_

Serious Injuries/surgeries w/ dates: Yes No \_\_\_\_\_

Other chronic conditions: Yes No \_\_\_\_\_

Any limits on physical activities: Yes No \_\_\_\_\_

Frequent Medications: Yes No \_\_\_\_\_

Doctor's note on file at Brookwood? Yes No \_\_\_\_\_

Any dietary restrictions? Yes No \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

I give permission to the staff at The Brookwood School to apply the following to my child's skin:

Sunscreen  Bacitracin/first aid ointment

Bug repellent  Diaper cream

I do not want anything applied to my child's skin.

I give permission for transport and treatment of my child in case of serious illness or injury. Yes No (You will be notified as soon as possible).

If not, what are your emergency plans? \_\_\_\_\_

I will allow medical information about my child to be shared with school personnel and the doctor's office as needed. Yes No

Parent/Guardian Signature \_\_\_\_\_ Print name \_\_\_\_\_