**Emergency Medical Form • Required for ALL Children**

Child #1 Last First Sex (M) (F) Age Date of Birth / / Child #2 Last First Sex (M) (F) Age Date of Birth / / Child #3 Last First Sex (M) (F) Age Date of Birth / / Address City ST ZIP Home Phone:

For emergency **first** call: Home: Cell: Work:

Secondary emergency call: Home: Cell: Work:

Family Physicians: First Choice: Phone:

 Second Choice: Phone:

Family Dentist: Phone:

If the physicians of your choice cannot be reached, may we have your permission to call a school physician? [ ] Yes [ ] No

Hospital of choice: [ ] Stamford Hospital [ ] Norwalk Hospital [ ] Other:

I hereby give my consent for the administration of non-aspirin medication by the Nurse or her designee for the relief of pain or headaches.

Signature of Parent/Guardian: Date:

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**MEDICAL CONDITION**: Does your child have any medical condition that we should be aware of for his/her health and safety? [ ] No [ ] Yes

If “Yes”, please explain:

**ALLERGIES**: Does your child have any \*allergies? [ ] No [ ] Yes

My child is allergic to \*Please alert the DSS Nurse about food or insect allergies that are life-threatening.

**MEDICATIONS**: Is your child taking any medication currently? [ ] No [ ] Yes

If “Yes”: list the medication name and dosage:

**MEDICATIONS DURING DSS HOURS**: If your child will be required to receive over-the-counter or prescribed medications during summer school hours please bring them to the DSS Nurse at DHS. All medications will be dispensed by the DSS Nurse.

**IMMUNIZATIONS**: If your child is **not** enrolled in the Darien schools please provide the nurse with a copy of your child’s immunization history.

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**Please complete EITHER Part 1 OR Part 2 below:**

**Part 1:** In the event reasonable attempts to contact me (parent/guardian) or other names listed have been unsuccessful, I hereby give my consent for the administration of any emergency treatment necessary by the available licensed physician or dentist. This consent does not cover major surgery unless the medical opinions of two other licensed physicians or dentists are obtained prior to the performance of such surgery.

*Signature of Parent/Guardian*: Date:

**Part 2:** I do not give consent for any emergency treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to do the following:

*Signature of Parent/Guardian*: Date: