

**MARLBORO ACADEMY**  
**STUDENT MEDICAL EMERGENCY INFORMATION**  
**2024-2025**

It is the parent's responsibility to keep all information current throughout the school year.

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

Date of Birth: \_\_\_\_\_ Primary Email: \_\_\_\_\_

Please indicate the order of preference you wish the school to contact:

Mother's Name: \_\_\_\_\_

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

Father's Name: \_\_\_\_\_

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

**Student Insurance Verification**

Name of Health Insurer: \_\_\_\_\_

Student's Physician & Phone Number: \_\_\_\_\_ Policy # \_\_\_\_\_

**EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT**

I \_\_\_\_\_ the parent or guardian of \_\_\_\_\_.

recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance.

Please make the following notation on my child's records:

- Allergies to medications/foods/latex/insect stings & bites/other:

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

- Chronic conditions (indicate medication & condition):

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

- Relevant medical information (e.g., contact lens wearer, seizures, heart conditions, asthma, surgeries):

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

I give the school permission to share this information to protect the health or safety of my child or others.

**Signature of Parent or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

- ❖ May Tylenol be given during the school day?

Yes \_\_\_\_\_

No \_\_\_\_\_

- ❖ May Ibuprofen be given during the school day?

Yes \_\_\_\_\_

No \_\_\_\_\_

