



**Rio Rancho Public Schools**  
**S.A.F.E. Before and After School Program**  
**Medical Information Form**

**Summer Program - June 1-26, 2009**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Grade:** \_\_\_\_\_

Please indicate if student has had or is currently under treatment for any of the following conditions (provide year or age when problem occurred):

<input type="checkbox"/> Allergies (check all that apply) <input type="checkbox"/> Seasonal <input type="checkbox"/> Food <input type="checkbox"/> Bee Sting <input type="checkbox"/> Animals <input type="checkbox"/> Other _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Diabetes <input type="checkbox"/> Ear/Hearing <input type="checkbox"/> Mental Health <input type="checkbox"/> Seizure <input type="checkbox"/> Heart Problem (type) _____  <input type="checkbox"/> Hepatitis (type) _____ <input type="checkbox"/> Hospitalized for serious illness, surgery or accidents  <input type="checkbox"/> <b>My child has no known health conditions</b>	<input type="checkbox"/> Meningitis <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Muscular Weakness or Paralysis <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Infectious Diseases <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Reactions to Medications or Injections <input type="checkbox"/> Need antibiotic therapy before dental treatment. Why? _____ <input type="checkbox"/> Long Term Medications, please list _____ <input type="checkbox"/> Other health conditions not listed _____
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**Emergency Contact Information other than parent or guardian:**

Name	Relationship	Phone #1	Phone #2

**Insurance Information:**

Students Insurance (primary) \_\_\_\_\_ Subscribers Name \_\_\_\_\_ ID# \_\_\_\_\_

In case of an emergency involving my child AND I CANNOT BE REACHED, I hereby give consent to transport my child to the following medical care providers/hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Physician/Nurse Practitioner or Physician Assistant \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist \_\_\_\_\_ Phone # \_\_\_\_\_ Hospital \_\_\_\_\_ Phone # \_\_\_\_\_

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CAN BE REACHED, I authorize appropriate transport and medical care of my child to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with the section. It is understood that I will be financial responsibly for all emergency care.

I authorize the Safe Schools staff to contact my child's providers listed above regarding medical management of my child. I understand information on this form will be shared with appropriate personnel on an as-needed basis only.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_