



**Far Hills Country Day School 2016-17
EMERGENCY INFORMATION FORM**

Student's First Name: _____ Last Name: _____

Date of Birth: _____ Grade for coming year: _____

Physician's Name: _____ Phone: _____

Medical Insurance Company: _____

Policy Number: _____

LIST ALLERGIES TO:

Food: _____

Medication: _____

Other: _____

Bee Stings: Yes _____ No _____

In the event that a parent cannot be reached, I hereby give permission to the Far Hills Country Day School to obtain emergency medical treatment for the above named child, including x-rays and to release information pertaining to my child's health record diagnosis, condition or health history, including any subsequent diagnosis which could supplement this form. This information may be released by a properly authorized representative of the school responsible for my child during periods of time when the school nurse is unavailable or, when the student is away from school (i.e. sporting events, field trips, etc.). I agree that I am responsible for the cost of such medical treatment.

Parent Signature Date

Far Hills Country Day School has my permission to give acetaminophen with the discretion to the above named child, as designated in the Far Hills Medical Standing Orders issued by the school physician.

Parent Signature Date