

**EMERGENCY-MEDICAL
INFORMATION FORM**

**LAKE FOREST HIGH SCHOOL
Lake Forest, Illinois**

The Class Of: _____

Name of Student: _____ Date of Birth ____/____/____
Last Name First Name Middle Initial

Home address: _____ Home telephone: _____

Father's name: _____ Employer: _____ Work telephone: _____
 cell/pager #: _____

Mother's name: _____ Employer: _____ Work telephone: _____
 cell/pager #: _____

List an adult who will assume responsibility for the student if parent cannot be reached:

Name: _____ Relationship: _____

Address: _____ Home telephone: _____
 cell/pager #: _____

Physician: _____ Telephone: _____

Dentist: _____ Telephone: _____

In case my child needs emergency health care due to a sudden potentially serious illness or injury at school and it is impossible to contact me, I hereby give Lake Forest High School personnel my permission to arrange for or provide such care as is deemed necessary.
 Date: _____ Parent/Guardian signature: _____

HISTORY

ALLERGIES		CHRONIC OR RECURRING ILLNESS						
	Y	Year	Illness	Y	Year	Illness	Y	Year
Asthma			Convulsions			Strep Infections		
Drug (allergy)			Diabetes			T.B.		
Food (allergy)			Epilepsy			Emotional/Nervous		
Hayfever			Heart			Other		
Insect Stings			Orthopedic					
Skin (allergy)			Pneumonia			Hearing Loss		
			Rheumatic Fever			Glasses/Contacts		

Does your child have any physical handicaps (*other than above*)? _____ Explain: _____

Is there any reason that your child should not participate in all physical activities? _____ Explain: _____

Current Medications: (*Specify type and dosage*) _____

PLEASE USE REVERSE SIDE FOR ADDITIONAL INFORMATION