GERMAN -AMERICAN SCHOOL OF PALO ALTO

Medical Information Sheet

Students Full Name_____ Birth Date _____ Sex__ Age ___

Parent or Guardian_____ Home Phone _____ Work Phone_____

Home Address_____

Street & Number City State Zip

Name of relative (not living with family) or neighbor to be called if parent or guardian cannot be reached in an emergency.

1. _____

Name Street & Zip Area code Phone

2. _____

Name Street & Zip Area code Phone

Name and Address of Family Physician (if any) _____

Name

_____

Street & Zip Area code Phone

OR Health Plan Name and Number _____

Name Number

Check Box for YES

HEALTH HISTORY	**ALLERGIES**	**DISEASES**	**PHYSICAL DISABILITIES**
o Ear Infections	o Hay Fever	o Chicken Pox	o Hearing Aid
o Rheumatic Fever	o Poison Oak	o Measles	o Dental Braces
o Convulsions	o Insect Stings	o German Measles	o Glasses/Contact Lenses
o Diabetes	o Penicillin	o Mumps	o Other
o Behavioral Problems	o Other Drugs	o Asthma	
	o Food (kind?)	o Hepatitis	
	o Other		

Date and Result of last Tuberculosis Test: _____

Date of last Tetanus Booster: _____

Details of any YES above (How do you handle it at home?_____

_____

Any restriction on physical activity? If NONE write NONE: If Yes Explain._____

_____

Medical Policy

If the parents can not be reached in case of an emergency, the school will take the child to a nearby urgent care clinic, usually Palo Alto Clinic.

In case of an extreme emergency, the school will call an ambulance.

Medical Release

I hereby release the German-American School of Palo Alto, its employees and Board members from any and all liability for injuries and illness that may occur while the child is at the school.

I give consent for school personnel to authorize emergency medical treatment for my child and I accept full financial responsibility for said treatment.

_____ _____

Date Signature of parent or guardian