Preschool Emergency Medical Card

TRANSPORTATION SERVICES
Confidential EmergencyInformation

The following information must be provided on a yearly basis by parent/guardian for students requiring transportation

PLEASE PRINT ALL INFORMATION

Student Name:	Birth Date:
School:	Date:

Photograph Here

A. IDENTIFYING INFORMATION

Height:	Weight:	Hair Color:	Visually Impaired YES NO	Hearing Impaired: YES NO	Verbal: YES NO	Language Spoken:
Physical Disability YES NO	If Yes, please descrie the physical disability:					
Exceptionality (circle):	AU DB DD HI MU OI OHI SI TBI VI					
Special considerations which may affect transportation:						

B. FAMILY INFORMATION

Name of Parent/Guardian	Address:	Daytime Phone(s):
Name of other adult authorized to act on your behalf:		Daytime Phone(s):

C. EMERGENCY MEDICAL INFORMATION

Student's Doctor:	Phone:
Hospital Preference:	Phone:
Insurance Provider:	

D. MEDICAL HISTORY

Does the student have seizures? YES NO	If yes, describe symptoms:
On siezure med? YES NO	If yes, list names, dosage and frequency of medication:
Does student take other medication? YES NO	If yes, list names, dosage and frequency of medication:
Is student allergic to food or medication?	If yes, what?
Does student have any of the following? Asthma Bleeding Disorder Brittle Bones Diabetes Heart Disease Respiratory Problems	

E. CONSENT (Print Name)

I, _____ father, mother or legal guardian of _____ in the event of accident, injury or serious illness to him/her, do voluntarily hereby give consent to and authorize the school district to secure medical aid or transportaion to a medical facility. I understand that neither the school district nor the individual responsible for obtaining medical aid will be responsible for expense incurred. _____

Signature of Parent/Guardian Date