



# Gerstell Academy

2500 Old Westminster Pike  
Finksburg, MD 21048  
410-861-3000 • Toll Free 1-866-861-3300 • Fax 410-861-3006

## EMERGENCY INFORMATION AND MEDICAL RELEASE FORM 2009-10

This form is to be completed by Parents. **(Please print)**

**STUDENT'S NAME:** \_\_\_\_\_ (\_\_\_\_\_)  
Last First Middle Preferred Name

Student's Grade and Age: \_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Student's Residence: \_\_\_\_\_ / \_\_\_\_\_  
Street address City State Zip code

With whom does this student reside?

\_\_\_\_ Both Parents \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Guardian

TO SERVE YOUR CHILD IN CASE OF **ACCIDENT OR SUDDEN ILLNESS**, PLEASE FURNISH THE FOLLOWING REQUIRED INFORMATION.

**(1<sup>st</sup> CONTACT)**

Parent/Guardian: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Pager: \_\_\_\_\_  
Email: \_\_\_\_\_

**(2<sup>nd</sup> CONTACT)**

Parent/Guardian: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Pager: \_\_\_\_\_  
Email: \_\_\_\_\_

PLEASE LIST TWO NEARBY RELATIVES OR NEIGHBORS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Number: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION:**

Name of Main Insured Person(s): \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Medical Insurance Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_  
Medical Insurance Telephone Number: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Family Dentist: \_\_\_\_\_ Telephone number: \_\_\_\_\_  
Hospital Choice: \_\_\_\_\_  
Food Sensitivities: \_\_\_\_\_  
Drug Sensitivities: \_\_\_\_\_

Athletic Activities to be Restricted: \_\_\_\_\_

Special Medications or Dietary Regimen to be continued: \_\_\_\_\_

All medications to be taken at school must be administered through the Health Room. Appropriate medication forms must be on file.

List any health conditions such as heart disease, diabetes, epilepsy, allergies, eye or ear problems, or any chronic problems etc.:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DISCRETIONARY ITEMS** The nurse or designee in her absence may administer the following over-the-counter items to this child as needed: (Check those we **MAY** give) Neosporin \_\_\_\_\_, Peroxide \_\_\_\_\_, Throat Lozenges \_\_\_\_\_, Anti-itch lotion or spray (Cortisone) \_\_\_\_\_, Sunscreen \_\_\_\_\_, Rubbing Alcohol \_\_\_\_\_.

Please list this child's sibling(s), age(s), and school(s):

Sibling 1: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Sibling 2: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Sibling 3: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

Sibling 4: \_\_\_\_\_ Age: \_\_\_\_\_ School: \_\_\_\_\_

AS A GENERAL RULE, GERSTELL ACADEMY WILL ATTEMPT TO CONTACT THE PARENTS, LEGAL GUARDIANS, ASSIGNED RESPONSIBLE RELATIVES OR NEIGHBORS FIRST. IN THE EVENT CONTACT CANNOT BE MADE, I UNDERSTAND AND HEREBY AUTHORIZE AND CONSENT TO THE HEAD OF GERSTELL ACADEMY OR HIS/HER AGENT TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR MY CHILD.

I FURTHER AGREE TO PAY AND TO HOLD GERSTELL ACADEMY HARMLESS ON ACCOUNT OF ANY MEDICAL, DENTAL, HOSPITAL, TRANSPORTATION OR OTHER RELATED CHARGES INCURRED ON BEHALF OF THE CHILD.

I GIVE PERMISSION FOR THE SCHOOL NURSE TO SHARE INFORMATION RELEVANT TO MY CHILD'S HEALTH CONDITION WITH APPROPRIATE SCHOOL PERSONNEL WHEN NEEDED TO MEET MY CHILD'S HEALTH AND SAFETY NEEDS.

THANK YOU.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Other Parent

\_\_\_\_\_  
Date