Brazosport Independent School District
Health Services ★

Brazosport ISD Medical Emergency Form

Student's Legal Name: _____ School Year: _____
Last First Middle

Date of Birth _____ Sex: M _____ F _____ Grade: _____
Month Day Year

Student's Physician's Name: _____ Address: _____ Phone: _____

The student lives with: (circle one) Father Mother Both Guardian Other (please specify) _____

_____ _____ _____
Mother/Guardian Name Cell Phone Work Phone

_____ _____ _____
Father/Guardian Name Cell Phone Work Phone

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF THE STUDENT IF YOU CANNOT BE REACHED.

1._____ _____ _____ _____
Name Relationship to Student Work Phone Cell Phone

2._____ _____ _____ _____
Name Relationship to Student Work Phone Cell Phone

Does the student currently have any of the following conditions? If yes, please explain.

Yes No Asthma that requires use of a daily inhaler? (Name of Inhaler)_____
Yes No Does your student have a life threatening allergy that requires the use of an epipen? If yes, my student is allergic to:
_____
Yes No Diabetes_____
Yes No Hearing Impairment?_____
Yes No Heart Condition_____
Yes No ADD/ADHD that requires medication administration at school? (Name of Medication)_____
Yes No Stomach/Colon Disorder_____
Yes No Kidney Disorder_____
Yes No Orthopedic Impairment_____
Yes No Seizure Disorder/Epilepsy (Name of Medication)_____
Yes No Visual Impairment?_____
Yes No Takes prescribed medication daily at home (Name of medication)_____
Yes No Needs to take daily medication at school (Name of medication)_____
Yes No Restricted activities due to physical or medical condition_____
Yes No Other Disability/Health Problem_____

Students MUST have a current Doctor note on file in order to carry epi-pens, asthma inhalers and diabetic supplies.

***** NOTE: All medications MUST 1. Be transported to and from school by parent or guardian. 2. Have a parent/guardian permission note to be given at school. 3. Be in the original bottle/container.**

IN THE EVENT OF AN EMERGENCY, I HEREBY AUTHORIZE B.I.S.D OFFICIALS TO SECURE MEDICAL TREATMENT. I UNDERSTAND THE STUDENT IS GENERALLY TRANSPORTED BY AMBULANCE TO THE NEAREST EMERGENCY CARE FACILITY. I WILL NOT HOLD THE SCHOOL DISTRICT OR ITS EMPLOYEES FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND / OR TRANSPORTATION FOR SAID STUDENT.

Parent/Guardian Signature *(REQUIRED*) **Date**