Aptakisic-Tripp Community Consolidated School District 102
1231 Weiland Road, Buffalo Grove, Illinois 60089
Phone: 847-353-5650 Fax: 847-353-5663 www.d102.org
Dr. Theresa Dunkin, Superintendent
Stacey Bachar, Asst. Superintendent Business Services
Dr. Robert Hudson, Asst. Superintendent Teaching & Learning
Megan Clarke, Director of Student Services

Emergency Treatment/ Health Information 2011-2012

To meet your child's health needs in school, please complete the information requested below.

_____ _____ _____ _____
Student Name Birth Date Grade (August) School

1. Does your child wear glasses? Yes ____ No ____ Contact Lens? Yes____ No ____

2. Does your child have a history of hearing problems? Yes ____ No ____

3. Check any of the following conditions that apply to your child:
Asthma _____ Diabetes _____ Migraines _____ Stomach _____ Orthopedic _____
Seizure _____ Heart _____ Urinary _____ ADD/ADHD _____ Other (describe) _____
Is your child presently under treatment/medical care for this condition? Yes ____ No ____
Doctor's name: _____ Phone: _____

4.Does your child currently take medication? Yes _____ No _____
If yes, name of medication _____ Dose _____ Time _____
Reason for medication _____

5. Does your child have a **LIFE THREATENING** allergy to egg, fish, milk, peanut, shellfish, soy, tree nut, or wheat?
Yes _____ No _____If yes, please circle all that apply.
Does your child have a **LIFE THREATENING** allergy to bee sting? Yes ____ No _____
Do any of the above allergies require an Epipen? Yes _____ No _____

6. Is your child lactose intolerant to dairy products? Yes ____ No ____

PARENT/ GUARDIAN CONSENT FOR EMERGENCY TREATMENT

I, _____ parent (or legal guardian) of _____
(parent name (student name)
have enrolled my child in **Aptakisic-Tripp School District 102** and hereby authorize my child's physician, or any physician in his or her group practice, on my behalf to administer emergency medical assistance to my child during school or a school sponsored activity. In the event my child's physician or any physician in his/her group practice is not available, I hereby authorize School District 102, its employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed physician whenever it is deemed necessary to protect the health, safety and welfare of my child. I further waive any claims against School District 102, the members of the Board of Education, its employees and agents as a result of emergency medical assistance rendered to my child. I also agree to hold harmless and indemnify School District 102, the members of the Board of Education, its employees and agents (either jointly or severally), from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs and expenses, including attorney's fees, resulting from or arising out of the provision of our arrangement for emergency medical treatment.

_____ _____ _____
Parent/ Guardian Signature Phone in an Emergency Date