ACES STUDENT EMERGENCY MEDICAL CARD

School Year:_____ Grade:_____

Student Name: _____ Birthdate: _____ Home Phone: _____

Address _____ Town: _____ Zip Code: _____

Legal Guardian Name(s) _____ Relationship: _____

Cell Phone _____ Work Phone _____ Email _____

ADDITIONAL EMERGENCY CONTACTS please list as many as possible:

Name	Home Phone	Work Phone	Cell Phone	Relationship to Student

Primary Health Care Provider: _____ Phone: _____

Address: _____ Town: _____ Zip Code: _____

Hospital Preference (if possible): _____ **DDS Case Manager Name**: _____ Phone: _____

Group Home Name: _____ Supervisor: _____ Phone: _____

OTHER PHYSICIAN OR SPECIALIST (Psychiatrist, Orthopedist, Neurologist, etc.)

Name	Address/Town	Phone

(OVER)

Health Insurance Plan: _____

HEALTH HISTORY

	Please Check: NO	YES
• Asthma	☐	☐
• Seizures	☐	☐
• Diabetes	☐	☐
• Glasses	☐	☐
• Hearing Aid	☐	☐

• Adaptive Equipment _____

Date of last hospitalization: _____

Reason: _____

KNOWN ALLERGIES

Please Check:

☐ No known allergies

PLEASE CHECK IF YES		DESCRIBE ALLERGIC REACTION
• Foods	☐	
• Bee stings	☐	
• Medications	☐	
• Latex	☐	

Has the student ever had an Epi-Pen ordered by a medical provider? ☐ NO ☐ YES

If yes, is it still required? ☐ NO ☐ YES

PRESENT MEDICATIONS - LIST NAME OF MED / DOSAGE / TIMES PER DAY:

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

_____ _____

Signature of Parent/Legal Guardian **Date**

ANS-18 Rev. 4/14

ACES STUDENT EMERGENCY MEDICAL CARD

School Year: '14 - '15 Grade: _____

Student Name: _____ Birthdate: _____ Home Phone: _____

Address _____ Town: _____ Zip Code: _____

Legal Guardian Name(s) _____ Relationship: _____

Cell Phone _____ Work Phone _____ Email _____

ADDITIONAL EMERGENCY CONTACTS please list as many as possible:

Name	Home Phone	Work Phone	Cell Phone	Relationship to Student

Primary Health Care Provider: _____ Phone: _____

Address: _____ Town: _____ Zip Code: _____

Hospital Preference (if possible): _____ **DDS Case Manager Name**: _____ Phone: _____

Group Home Name: _____ Supervisor: _____ Phone: _____

OTHER PHYSICIAN OR SPECIALIST (Psychiatrist, Orthopedist, Neurologist, etc.)

Name	Address/Town	Phone

(OVER)

Health Insurance Plan: _____

HEALTH HISTORY

	Please Check: NO	YES
• Asthma	☐	☐
• Seizures	☐	☐
• Diabetes	☐	☐
• Glasses	☐	☐
• Hearing Aid	☐	☐

• Adaptive Equipment _____

Date of last hospitalization: _____

Reason: _____

KNOWN ALLERGIES

Please Check:

☐ No known allergies

PLEASE CHECK IF YES		DESCRIBE ALLERGIC REACTION
• Foods	☐	
• Bee stings	☐	
• Medications	☐	
• Latex	☐	

Has the student ever had an Epi-Pen ordered by a medical provider? ☐ NO ☐ YES

If yes, is it still required? ☐ NO ☐ YES

PRESENT MEDICATIONS - LIST NAME OF MED / DOSAGE / TIMES PER DAY:

1.	4.	7.
2.	5.	8.
3.	6.	9.

_____ _____

Signature of Parent/Legal Guardian **Date**

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