McGinnis Woods Country Day School

EMERGENCY MEDICAL INFORMATION

****All blanks MUST be completed****

(please print, only one child per form)

Child's Last Name _____ Child's First Name _____

Home Phone: _____
☐ **No Home Phone**

Father's Name: _____

Work Phone: _____ Cell Phone: _____

Mother's Name _____

Work Phone: _____ Cell Phone: _____

Child's Physician: _____ Office Phone: _____

Physician's Address: _____

Allergies: _____
☐ **No Allergies**
*****All food allergies require written documentation from a physician

Special Medical Needs/conditions: ☐ **Asthma Other: _____**
☐ **No Special Medical Needs/conditions**

Daily Prescribed Medications: _____
☐ **No Daily Prescribed Medications**

Emergency Medical Facility: Emory Johns Creek Hospital
6325 West Johns Crossing
Suwanee, Georgia 30097
(678) 474-7000

(OR THE CLOSEST EMERGENCY MEDICAL FACILITY AT THE TIME OF THE INCIDENT)

I believe the above information to be true and correct. It is my responsibility, as the child's parent / guardian to immediately update this form if any information should change. We hereby grant MCGINNIS WOODS COUNTRY DAY SCHOOL permission to take whatever action in its judgement may be necessary in supplying emergency medical services to the above named child. We hereby agree that we will be solely responsible for and will promptly pay any expenses incurred by MCGINNIS WOODS COUNTRY DAY SCHOOL in making emergency medical treatment available to the above named child.

_____

(Parent's signature) **(Date)**