



# STUDENT CLINIC CARD

Stock# 90860

Revised 3/11

SCHOOL _____ YEAR _____	TEACHER _____ GRADE _____ BUS# _____	
Student Name (Last, First):	Student ID:	
Address:	Date of Birth:	
<b>Parent / Legal Guardian Information</b>		
Mother's Name:	Father's Name:	
Tel. #(home): _____ (work): _____	Tel.# (home): _____ (work): _____	
Mother (cell):	Father (cell):	
Email Address:	Email Address:	
In the event the parent/guardian cannot be reached, the following are authorized to pick up my student		
<b>Name</b>	<b>Relationship</b>	<b>Telephone</b>
I understand that in the event the parent/guardian cannot be reached, the school has my permission to take appropriate emergency action including calling 911. I understand it is also my responsibility to update phones and medical information.		
<b>SIGNATURE:</b> _____		<b>DATE:</b> _____
Signature of Parent / Legal Guardian		
↓ <b>COMPLETE OTHER SIDE</b> ↓		

**NAME:** \_\_\_\_\_

**MEDICAL CONDITIONS (such as asthma, seizure disorder, diabetes, bleeding disorder, heart or stomach problems, etc)**

**NO  YES  If yes, please list and explain.**


**ALLERGY TO MEDICATION, FOOD, INSECT, LATEX, OTHER? NO  YES  If yes, please list and explain.**

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**Does your child take any MEDICATIONS?(routine/emergency) NO  YES  If yes, please list medication and reason taken.**

**Medications**

**Reason Taken**

Medications	Reason Taken

**List others in your household attending Gwinnett County Public Schools**

**Name**

**Relationship**

**School Attending**

Name	Relationship	School Attending