

Omro High School Emergency Treatment Form
2015 - 2016

Name: _____ Date: _____

Address: _____

Phone #: _____ Age: _____ Grade: _____

DOB: _____

Parents or Guardians: _____

Phone Numbers of Parents/Guardians:

Daytime: _____

Nighttime: _____

Cell: _____

If no one can be reached at these numbers call:

1. a) Name: _____

b) Relationship: _____

c) Phone #: _____

d) Cell #: _____

2. a) Name: _____

b) Relationship: _____

c) Phone #: _____

d) Cell #: _____

Medical History

Contacts: Y N Asthma: Y N Allergies: Y N
To What? _____

Problems with Bee Stings: Y N Treatment Kit: Y N

Seizures: Y N Last Date: _____

Broken bones in the last three year: Y N

If yes, what and when? _____

Hyperventilating problems: Y N

Medications you are taking: _____

How much: _____

Any other problems to be aware of: _____

Parents/Guardians Signature: _____