Omro High School Emergency Treatment Form

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: _____