

Phone: 434-295-0457
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Little Keswick School

Incorporated

A Therapeutic, Special Education Boarding School for Boys
www.littlekeswicksschool.net

P.O. Box 24
Keswick, VA 22947

MEDICAL/DENTAL INFORMATION FOR EMERGENCY ACTIONS

This form must be completed by the parent/guardian.

1. Name: Last _____ First _____ Middle _____

D.O.B.: ____ / ____ / ____ Soc Sec # _____

2. **PHYSICIAN** to be notified in an emergency: _____

Address: _____ Telephone Number: _____

3. **DENTIST** to be notified in an emergency: _____

Address: _____ Telephone Number: _____

4. **USE OF MEDICATION** – List by name each prescription drug the child is authorized to use and state the times and conditions of use, e.g. 3 times daily, before meals only; use if in pain, etc.

5. Is this child allergic to any medication/foods/plants/insects? If so, name the allergen and describe symptoms and treatment below. Otherwise, state “No” or “Unknown”:

6. Does this child have any significant medical problems? () Yes () No
If “Yes,” describe below in some detail; state each health condition or problem separately and explain its effects, duration, treatment, etc.:

7. Does this child have any history of substance abuse? () Yes () No. If “Yes,” state below each substance by name and any known facts concerning its use by the child, e.g. length of use, treatment provided, most recent usage, etc.:

8. **Emergency contact: (other than parent/guardian)** _____

Address: _____ Telephone Number: _____

Additional Information:

Father's Full Name: _____ **SS #:** _____

Date of Birth of Father: ____ / ____ / ____ **Place of Birth:** _____

Father's Address: _____

Home Phone Number For Father: _____ **Emergency No.:** _____

Mother's Full Name: _____ **SS #:** _____

Date of Birth of Mother: ____ / ____ / ____ **Place of Birth:** _____

Mother's Address: _____

Home Phone Number For Mother: _____ **Emergency No.:** _____

9. Payment for the medical and/or dental services provided to this child will be made by the health insurance or other means indicated below:

Health insurance in name of: _____

1. Company Name: _____

Policy #: _____ Telephone #: _____
(Please attach copy of health insurance card or supply other written verification.)

2. Company Name: _____

Policy #: _____ Telephone #: _____
(Please attach copy of health insurance card or supply other written verification.)

MEDICAID coverage #: _____ MEDICARE coverage #: _____
(Please attach card and send new card monthly.)

Drug Card Information if applicable: _____

(Please attach copy of card)

OTHER MEANS (Identify): _____

EMERGENCY PROCEDURE: I hereby give permission to the physician selected by the administrators of Little Keswick School to hospitalize, secure proper treatment (including medical care, dental care and obtaining required immunizations for, and to order injection, anesthesia or surgery for my child as named above.)

Signed: _____ Date: _____

Parent/Legal Guardian