Student Health and Emergency Information Form

Student's Name: Last: ________________________________First:______________________________M/F

Date of Birth: _______________ Telephone #: ________________________________

Student Address: ____

Student's Doctor: ____ Tel. #: ________________________

Hospital of Choice: ___________________________Medical insurance: ______________________________

In case of emergency, illness, or injury, it may be necessary to contact Parent, Guardian or Designated Adult. Please complete the following so that the school has correct and up-to-date information.

Relationship to student (check one): ( ) Parent ( ) Guardian ( ) Designated Adult

Name: ___________________________________ Address: _____________________________________

Home phone: _______________________ Cell phone: _______________________

Work phone: ________________________ Email: ____

In case of emergency and the above person cannot be reached, CONTACT:(list more than one tel.# if needed)

Name: ____ Relationship: _______________________________

Tel. #______________________________________

Name: ____ Relationship: _______________________________

Tel. #______________________________________

In the case of headache, minor injury, or illness, I give the School Nurse permission to administer the age/weight appropriate dose of the following medications: (please check)

( ) Acetaminophen/Tylenol ( ) Antihistamine/Benadryl

( ) Ibuprofen/Advil ( ) Antacid/Tums

Does your child take daily medication at home? YES/NO **(List medications below. Use reverse if necessary.)**

1) Medication/dose/frequency:
   Reason:

2) Medication/dose/frequency:
   Reason:

3) Medication/dose/frequency:
   Reason:

4) Medication/dose/frequency:
   Reason:

Does your child have **allergies**? YES/NO If yes, is he/she allergic to:

FOOD YES/NO ____

INSECTS YES/NO____

MEDICATIONS YES/NO____

OTHER (i.e. Seasonal) YES/NO____

Has your child been prescribed <u>epinephrine (ie, epi-pen) for an allergy</u>? YES/NO ***If YES, please CONTACT THE SCHOOL NURSE, complete medication orders & consent form (attached) and provide the school with his/her prescribed epinephrine auto-injector.***

Does your child have asthma? YES/NO Take asthma medication? YES/NO Specify ______________________

If "yes", your child **<u>MUST</u>** have his/her prescribed inhaler at all times during school

Does your child have any other health concerns? _____________________________(use reverse if needed)

Does your child wear glasses/contact lenses? YES/NO

Does your child have a hearing difficulty? YES/NO Wear a hearing aid? YES/NO

I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. <u>I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.</u>

Parent/Guardian Signature: ____________________________________Date: ________________________

Student Signature: ____Date: ________________________

List any medications and/or health concerns that are continued from previous page:

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