Student Emergency and Health Information

Student's Name_____Grade_____Date of Birth_____
Parent's Name_____
Mailing Address__PO Box_____Town_____Zip Code_____
Physical Address(if different from mailing address)_____
_____
Father's Work Place_____hours_____Phone_____
Mother's Work Place_____hours_____Phone_____
Father's Cell_____Mother's Cell_____Student's Cell_____
Parent's Email_____ _____
Person to contact if parents cannot be reached (someone local) Name and phone #
_____

Please check the appropriate answer:

Does your child have any health conditions or allergies? ____Yes ____No If yes, please indicate: Allergic to:
____Medication ____Food ____Environmental ____Seasonal/Hayfever ____Bee Stings (mild or severe) circle
List:_____

____Asthma ____Diabetes ____Hearing Loss ____Physical handicap (describe)_____
____Convulsive seizures ____Wears glasses/contacts ____Other_____

Has your child ever had: ____meningitis ____head trauma/skull fracture ____cancer or____been treated for serious infection
Additional information_____
Does your child take any medication or an inhaler on a regular basis? ___Yes ___No
If yes, please list medications_____
Will they take this medication at school? ___Yes ___No (if yes to either question, contact nurse)

I understand if my child needs an inhaler or takes medication at school, it must be in the original, labeled container and the authorization forms must be on file. Please contact the school nurse for required forms.

_____Yes My child has permission to take over the counter medicines such as but not limited to: Tylenol, Tums
_____No My child is not to receive any medications at school unless verbal permission is obtained from me.

Family Doctor_____Office Phone_____
Family Dentist_____Office Phone_____
Preferred Hospital_____

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgement in calling medical personnel for transport to local medical facilities. Likewise, your signature below authorizes the release of medical records pertinent to such an emergency room visit. This is a general authorization and is not sufficient for the release of confidential information protected by Federal Law. **Special Note:** If at anytime this information changes, these changes must be submitted to the administration in writing.

_____ _____
Parent Signature Date