

EMERGENCY & HEALTH INFORMATION

IMPORTANT! RETURN ASAP

Student's Name _____ Grade _____ Date of Birth ___ / ___ / ___ Today's Date ___ / ___ / ___

Parent's Name _____ Phone _____

Home Address _____ Cell Phone _____

Father's Place of Work _____ Working Hours _____ Phone _____

Mother's Place of Work _____ Working Hours _____ Phone _____

Other _____ Email address if available _____

Person to contact if parents are not available. (List someone locally. This must be filled out.)

Name _____ Address _____ Phone _____

____ Yes My child has my permission to take over the counter medicines such as but not limited to: Tylenol, Cough drops, Tums.

____ No My child is NOT to receive any medications at school unless verbal permission is obtained from me.

Additional information _____

Does your child take any **medications** on a regular basis? ____ Yes ____ No If yes, please list _____

Will they take any at school? ____ Yes ____ No Do they carry an **inhaler** for asthma, etc? ____ Yes ____ No **If yes to either contact nurse.**

Does your child have any health conditions or allergies? ____ Yes ____ No If yes, please indicate:

Allergy(ies): ____ Medication; ____ Food; ____ Environmental; ____ Seasonal/Hayfever; Bee Stings ____ Mild ____ Severe Tx: _____

(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 a serious infection?

Family Doctor _____ Office Phone _____

Family Dentist _____ Office Phone _____

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 judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below authorizes the release of medical records pertinent to such an emergency room visit, as the School District may require for its files. This is a general authorization and is not sufficient for the release of confidential information protected by Federal Law.

SPECIAL NOTE: At anytime when the above information changes, these changes must be submitted to the administration in writing.

I understand if they use/carry an inhaler or take medication at school, it must be in the original, labeled container and the authorization forms must be on file. Please contact school nurse or office for required forms.

Parental Signature _____ Date _____