Emergency Health Information

STUDENT INFORMATION			GRADE _____
Student ID #:	Last Name:	First Name:	Middle Initial:
Gender:	Enroll Date:	Date of Birth:	
Address:			
Home Phone #:	Cell #	Parent Contact Language:	
Last School Attended:			

PRIMARY FAMILY CONTACTS (WHO WE WILL CALL FIRST)				
Parent/guardian name:	Relationship:	Work number:	Cell number:	Lives with Circle one: yes no
Parent/guardian name:	Relationship:	Work number:	Cell number:	Lives with: Circle one: yes no

EMERGENCY CONTACTS (WHO WE WILL CALL IF PARENT/GUARDIAN CANNOT BE REACHED)				
Name:	Relationship:	Home Phone:	Cell:	Work:
Name:	Relationship:	Home Phone:	Cell:	Work:
Name:	Relationship:	Home Phone:	Cell:	Work:
Name:	Relationship:	Home Phone:	Cell:	Work:

STUDENT HEALTH HISTORY: ☐ MY CHILD HAS NO HEALTH CONDITIONS (INCLUDING THOSE LISTED BELOW) ☐ MY CHILD HAS THE FOLLOWING HEALTH CONCERN(S):

Allergies: Food (List):	Has EpiPen Prescription: Y N	Other Allergy (List):	Seasonal: Y N
ADHD	Psychiatric	Ear/Nose/Throat	Pulmonary (Other than Asthma)
Asthma Needs Inhaler at School: Y N	Eye/Vision	Cancer	Cardiovascular (List)_____ High Blood Pressure: Y N
Dermatologic/Skin Diabetes (circle one) Type 1 Type 2	Neurological Migraines Seizures: Type_____	Stomach/GI	Musculoskeletal
Wears glasses/contacts: Y N Wears hearing aids/device: Y N	Eating Disorder	Bladder/GU	Dental/Oral
	Endocrine Other than Diabetes	Hematology/Bleeding Disorders	Congenital/Genetic

**Any Other Health Conditions: List on Back

Medications taken on a daily basis:

Student's Health Insurance:	Subscribers Name:	ID#

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Healthcare Provider:	Phone:
Dentist:	Phone:
Hospital:	Phone:

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CAN BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this card will be shared with appropriate personnel on an as-needed basis only. I understand health screenings may be done unless I provide the school health office with written notification requesting exclusion from these screenings.

Parent/Guardian Signature: _____ Date: _____

FIRST NAME:

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Student Name: ______________________________

Other Health
Conditions: ____
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FOR HEALTH OFFICE USE ONLY

IHP **Action Plan** ________________ **Epi Pen** **Inhaler** **Glucagon** **Diastat** **Meds**

Nurses
Notes: ____
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____
____
____
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HEALTH OFFICE VISITS (FOR USE ONLY IF SIS IS UNAVAILABLE)

Date	Time In	NOTES	Time Out	Signature