

HEALTH AND EMERGENCY UPDATE FORM 2017-2018

STUDENT'S LAST NAME _____ FIRST _____ GRADE _____

HOME PHONE _____

MALE FEMALE

BIRTH DATE _____

BIRTH PLACE _____

MOTHER'S NAME _____

FATHER'S NAME _____

PLACE OF BUSINESS _____

PLACE OF BUSINESS _____

HOURS & WORK PHONE _____

HOURS & WORK PHONE _____

CELL PHONE _____

CELL PHONE _____

IF APPLICABLE, MAY RELEASE TO :

STEPMOTHER'S NAME _____

STEPFATHER'S NAME _____

PLACE OF BUSINESS _____

PLACE OF BUSINESS _____

HOURS & WORK PHONE _____

HOURS & WORK PHONE _____

CELL PHONE _____

CELL PHONE _____

EMERGENCY CONTACT(S) TO TAKE HOME OR TO SEEK MEDICAL TREATMENT IF PARENT/STEPPARENT(S) CANNOT BE REACHED:

NAME _____

NAME _____

RELATION _____

RELATION _____

PHONE NUMBER _____

PHONE NUMBER _____

HEALTH INFORMATION

DOES STUDENT HAVE A MEDICAL CONDITION THAT MAY/WILL REQUIRE SUPERVISION OR RESTRICT ACTIVITY? YES NO

IF YES, PLEASE EXPLAIN: _____

PLEASE NOTE IF ANY OF THE FOLLOWING CONDITIONS PERTAIN TO YOUR CHILD:

- | | | |
|--|---|--|
| <input type="checkbox"/> ANEMIA OR BLEEDING DISORDER | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> KIDNEY CONDITIONS |
| <input type="checkbox"/> ASTHMA / REACTIVE AIRWAY | <input type="checkbox"/> NEUROLOGICAL CONDITION | <input type="checkbox"/> MONONUCLEOSIS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> CHRONIC RESPIRATORY PROBLEM |
| <input type="checkbox"/> SEIZURE DISORDER | <input type="checkbox"/> HEART CONDITION | <input type="checkbox"/> SURGERIES** |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEARING/EAR CONDITIONS | <input type="checkbox"/> INJURIES / FRACTURES** |

DETAILS: **PLEASE LIST DATES ALSO _____

ALLERGIES: FOOD _____ INSECT STING _____ NUT ALLERGY _____
 MEDICATION _____ OTHER _____

PLEASE LIST ANY MEDICATION THE STUDENT MAY CARRY, INCLUDING OVER THE COUNTER MEDICATIONS SUCH AS TYLENOL, MOTRIN, MIDOL: _____

******PLEASE KEEP IN MIND THAT A DOCTOR'S ORDER FOR ALL MEDICATION, INCLUDING OVER THE COUNTER MEDICATION, MUST BE ON FILE IN THE HEALTH OFFICE.**

NAME OF DOCTOR _____ PHONE _____

IS THE STUDENT PRESENTLY UNDER THE CARE OF A MEDICAL DOCTOR? YES NO

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I WILL NOTIFY THE SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES. I UNDERSTAND THAT THIS INFORMATION MAY BE SHARED WITH PERSONNEL INVOLVED WITH MY CHILD. I GIVE MY PERMISSION FOR MY STUDENT TO BE RELEASED TO THE STEPPARENT(S), IF APPLICABLE.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PLEASE RETURN TO THE SCHOOL NURSE WITH YOUR STUDENT'S REGISTRATION MATERIALS.