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:

☐ANEMIA OR BLEEDING DISORDER	☐PNEUMONIA	☐KIDNEY CONDITIONS
☐ASTHMA / REACTIVE AIRWAY	☐NEUROLOGICAL CONDITION	☐MONONUCLEOSIS
☐RHEUMATIC FEVER	☐TUBERCULOSIS	☐CHRONIC RESPIRATORY PROBLEM
☐SEIZURE DISORDER	☐HEART CONDITION	☐SURGERIES**
☐DIABETES	☐HEARING/EAR CONDITIONS	☐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.