

Emergency Information Update

In an effort to maintain up to date medical information and emergency phone numbers, we are asking you to complete the following form and return it to the nurse.

Today's date: _____ Student's grade: _____

Student's Full Name: _____ **Home phone number:** _____

Address: _____

Place of birth, City and State: _____

Mother's Name: _____ **Work phone number:** _____
Occupation: _____ **Cell phone number:** _____

Father's Name: _____ **Work phone number:** _____
Occupation: _____ **Cell phone number:** _____

Student lives with: (Circle one) Both Parents Mother Father Other (please specify)

Guardian Name: _____ **Phone number:** _____

Custody Papers? YES OR NO

Emergency Contacts: In the event parents cannot be reached.

#1 Name: _____ Relationship: _____
Telephone number: _____

#2 Name: _____ Relationship: _____
Telephone number: _____

The school nurse has Tylenol, Antacid, and Sore throat lozenges available. Is your child permitted to have these?

Tylenol (Please circle one)	YES	NO
Antacid (Please circle one)	YES	NO
Sore throat lozenge (Please circle one)	YES	NO

The nurse also has topical creams available for cuts, burns, insect bites and stings. Is your child permitted to have these?

YES	NO
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Signature of Parent or Guardian: _____

Please complete the health history on other side.

HEALTH HISTORY

Name of student's doctor: _____ Phone: _____

Does your child have any of the following? Please mark all that apply.

___ Allergies: list all allergies _____

___ Bee Sting Allergy: list medications _____

___ Asthma: list medications _____

___ Diabetes Type I or Type II: list medications _____

___ Seizures: list medications _____

___ Heart murmur or other heart condition _____

___ Arthritis/Rheumatic Disease _____

___ Bleeding disorder _____

___ Cerebral Palsy _____

___ Cystic Fibrosis _____

___ Sickle Cell _____

___ Spina Bifida _____

___ Tourette's Syndrome _____

___ Autism: list treatments _____

___ ADHD: list medications _____

___ Eating Disorder _____

___ Vision problems _____

___ Hearing problems _____

___ No health problems

Please list any other medical conditions, physical defects, serious illnesses, operations or other medications taken regularly?

