EMERGENCY MEDICAL FORM

Your child's health is essential to his/her learning. Please take a moment to share information that will help us to care for your child during the school day.

Name of Student ______________________________ Date of birth __________ M __ F __ Grade ___

Ethnicity Hispanic YES __ NO __

Race (Please circle) White - American Indian or Alaska native - Asian - African American
Native Hawaiian or Other Pacific Islander - Two or more races

Name of parent/guardian __________________________ Town of residence _______________
Phone 1: ___________________ Phone 2: ___________________ Email ______________________
Mailing address ____

Name of parent/guardian __________________________ Town of residence _______________
Phone 1: ___________________ Phone 2: ___________________ Email ______________________
Mailing address ____

Is there a **court order** affecting your child in regard to guardianship, custody, residence, or visitation rights? YES __ NO __

Emergency contact information:
List two people who will assume temporary care of your child if you cannot be reached in an emergency or if your child needs to be dismissed from school.

Name 1: ___________________________ Relationship __________ Phone _____________________
Name 2: ___________________________ Relationship __________ Phone _____________________

Primary care doctor _________________________________ Phone ________________________

If your child would like to **participate in sports**, the nurse needs a copy of your child's most recent physical on file in her office. It is good for 2 years from the date of visit.

~ Form continues on other side ~

Does your child have a history of any of the following conditions? (please check boxes)

Condition	Yes	No	Condition	Yes	No
Food allergy			Asthma		
Medication allergy			Diabetes		
Insect sting allergy			Surgery within past year		
Concussion/head injury			Vision or hearing loss		
Headaches/migraines			Physical limitations		
Seizure disorder			Other chronic illness		

Please give details/dates for items checked above ______________________________

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Do you have any other concerns you want to mention? ___________________________

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List any medications your child takes at **home**: _______________________________

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List any medications your child will take at **school**: ___________________________

YES __ NO __ I give consent for the school nurse or authorized personnel to give **Acetaminophen** (Tylenol) in the appropriate dosage.

YES __ NO __ I give consent for the school nurse or authorized personnel to give **Ibuprofen** (Advil) in the appropriate dosage.

YES __ NO __ I give consent for the school nurse or authorized personnel to give **Calcium carbonate** (Tums) in the appropriate dosage.

YES __ NO __ I give consent to a written or verbal exchange of information between my child's primary care doctor and the school nurse for medical purposes. This will include, but not be limited to: immunization records, medication orders, asthma action plans, allergy action plans, seizure action plans, and physical exams.

I understand that, unless I cancel sooner, these consents are valid until October 12, 2018.

Parent signature ___________________________________ **Date** ______________