

EMERGENCY CONTACT AND HEALTH HISTORY FORM

OFFICE USE	STUDENT ID	NOTES				
1. STUDENT INFORMATION						
LEGAL NAME	Last:	First:	Middle:	GENDER	BIRTH DATE (mm/dd/yyyy) / /	GRADE
2. EMERGENCY CONTACT INFORMATION						
This information is being collected to provide for the student's health and safety at school. Refusal to supply emergency information could result in the school's inability to contact you in case of an emergency. In the event of an emergency and the school is unable to reach the parent, the school will secure emergency services (medical, dental, paramedic, ambulance) for my child, at parent expense. District Policy authorizes school staff to release private data to appropriate parties in connection with an emergency if the knowledge of the information is necessary to protect the health and safety of the student. I certify that all information below is accurate and that it is my responsibility to apprise the school of any changes in residency, phone numbers, and emergency release contacts.						
PARENT /LEGAL GUARDIAN / OTHER ADULT that lives with the student						
LEGAL NAME	Last:	First:	Middle:	GENDER	RELATIONSHIP	
HOME PHONE	() -	CELL PHONE	() -	WORK PHONE	() -	
LEGAL NAME	Last:	First:	Middle:	GENDER	RELATIONSHIP	
HOME PHONE	() -	CELL PHONE	() -	WORK PHONE	() -	
OTHER EMERGENCY CONTACT(S) – If possible please list at least two contacts						
LEGAL NAME	Last:	First:	Middle:	GENDER	RELATIONSHIP	
HOME PHONE	() -	CELL PHONE	() -	WORK PHONE	() -	
LEGAL NAME	Last:	First:	Middle:	GENDER	RELATIONSHIP	
HOME PHONE	() -	CELL PHONE	() -	WORK PHONE	() -	
LEGAL NAME	Last:	First:	Middle:	GENDER	RELATIONSHIP	
HOME PHONE	() -	CELL PHONE	() -	WORK PHONE	() -	
PRIMARY E-MAIL ADDRESS – Please list only one e-mail address			DOCTOR / CLINIC NAME		DOCTOR/CLINIC PHONE NUMBER	
					() -	
3. HEALTH HISTORY INFORMATION						
This information is required in order to provide appropriate health services for your student. This data will be treated as private data and will be recorded in the student health record. It will be shared with those working with your child only on a "need to know" basis and with emergency personnel in the event of an emergency.						
DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CHRONIC HEALTH CONDITIONS?	<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Other (Explain):		<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Kidney problems		<input type="checkbox"/> Sickle Cell disease / trait <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Vision Loss	
DOES YOUR CHILD HAVE ALLERGIES? <input type="checkbox"/> Yes <input type="checkbox"/> No			List:			
DOES YOUR CHILD HAVE AN EPI-PEN? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Epi-pen (prescribed) - will be kept in the nurse's office <input type="checkbox"/> Epi-pen (prescribed) – student will self-carry their Epi-pen			
DOES YOUR CHILD HAVE ASTHMA? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Inhaler / Neb (prescribed) – will be kept in nurse's office <input type="checkbox"/> Inhaler – student will self-carry their inhaler			
HAS YOUR CHILD BEEN HOSPITALIZED FOR ILLNESS, SURGERY, OR INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No			If YES, explain:			
DOES YOUR CHILD TAKE ANY MEDICATIONS? <input type="checkbox"/> Yes <input type="checkbox"/> No			If YES, list medications:			
4. PARENT/LEGAL GUARDIAN/OTHER PRIMARY CARE PROVIDER/EMANCIPATED STUDENT CERTIFICATION						
I CERTIFY THE INFORMATION GIVEN ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.						
PRINTED NAME _____		SIGNATURE _____			DATE _____	