**SCHOOL CITY OF WHITING**
**MEDICAL HISTORY/EMERGENCY AUTHORIZATION**
**SCHOOL YEAR**
**2023-2024**

Student's Name_____ M __ F__ Date of Birth_____ Teacher _____ Gr. ____
Address _____ Home Phone No._____
Parents/Guardian's Names_____ Guardian's Phone No._____
Father's Work No._____ Mother Work No._____
Father's Cell No. _____ Mother's Cell No._____
Name of previous school_____ Phone Number _____

PERSONS TO CONTACT IN AN EMERGENCY IF THE PARENT/GUARDIAN IS NOT AVAILABLE:
Name_____Relationship_____Phone_____
Name_____Relationship_____Phone_____
Physician's Name_____ Phone_____
Dentist's Name_____ Phone_____

**Allergies** ___No known Allergies ____food ____medication ____ insect ____ other_____
Type of reaction_____
Medication for reaction _____
*for severe reactions requiring an epi pen we need an action plan completed by a physician*
**Asthma** ___activity induced ___allergy induced ___anxiety induced ___other_____
___ student should stay inside if the temperature is below _____
Medication _____ _____as needed ___prior to exercise
*We need an asthma control plan completed yearly by a physician*
**ADD/ADHD** Medication _____ doctor_____
**Diabetes** ___Type 1 ___Type 2 Controlled by ___diet only ___diet and oral medication ___ insulin
*A diabetes plan must be completed by a physician yearly and updated as needed*

**Vision** ___Glasses___ Contacts ___ No problems **Hearing** ___Wears aids ___ No Problem

Please check any Conditions that pertain to your student:

___Seizures_____
___Lung Problems _____
___Headaches_____
___Skin conditions _____
___Urinary/kidney problems_____
___ Blood Disorders _____
___ Gastrointestinal problems _____
___ Other _____

Please list all daily medication with dosage, time given, and reason for medication.

_____

Please list any other information the school nurse should be aware of:

_____

This Information will be on file in the school nurse's office. All student health information is considered confidential and shared with teachers and administration if the health condition may impact classroom achievement or to maintain the health and well-being of the students. Information is shared on a "need to know" basis.

**In the event of an emergency, your child will be taken to the nearest hospital for treatment.**

1. I give Emergency Personnel permission to transport my child to an Emergency Room for treatment in my absence.
2. I grant permission for the school to release all medical information which they have to the Emergency Room personnel.
3. I also grant my permission for the staff at the Emergency Room to treat my child.

**PARENT/GUARDIAN SIGNATURE REQUIRED:**

X _____ _____
**Signature** **Date**