EMERGENCY MEDICAL FORM
2019/2020

Children's health is essential to their 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 _____ Grade _____

Gender _____ **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 _____

_____

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

_____

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

_____

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

I give consent for the school nurse or trained unlicensed school personnel to give:

YES___ NO___ **Tylenol** (Acetaminophen) in the appropriate dosage.
YES___ NO___ **Advil** (Ibuprofen) in the appropriate dosage.
YES___ NO___ **TUMS** (Calcium Carbonate) in the appropriate dosage.
YES___ NO___ **Cough Drops/Throat Lozenges**

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 16, 2020.

Parent signature _____ **Date** _____