**LEBANON PUBLIC SCHOOLS**
Lebanon Middle School
Jennifer Rahl, R.N.
jennifer.rahl@lebanonct.org
Phone: (860) 642-5630
Fax: (860) 642-3534

# STUDENT EMERGENCY INFORMATION 2023-2024

STUDENT NAME: _____ GRADE (2023-2024)_____
Last First

STUDENT ADDRESS:_____
Street Town

HOME PHONE: _____ BIRTHDATE (MM/DD/YY): ____/____/____

## PARENT / GUARDIAN INFORMATION

Mother's Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
Email Address: _____ Work Phone: _____
Employer: _____ Occupation: _____

Father's Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
Email Address: _____ Work Phone: _____
Employer: _____ Occupation: _____

Step-Parent/Guardian: _____ Home Phone: _____
Address: _____ Cell Phone: _____
Email Address: _____ Work Phone: _____
Employer: _____ Occupation: _____

## EMERGENCY CONTACTS

*List two (2) neighbors or relatives who will assume temporary care of your child if you cannot be reached. (They must drive and be at least18 years old.)*

1. Name/Town_____Relationship_____Phone: ( )_____
2. Name/Town_____Relationship_____Phone: ( )_____

Does your child have health insurance **Yes / No**
If not, would you like information involving the Connecticut Husky Plan? **Yes / No**

## AUTHORIZATION FOR FIRST AID, MEDICAL TREATMENT, TYLENOL/ADVIL OR OTHER MEDICATIONS

In case of accident, illness or injury, I grant permission for school personnel to administer first aid or secure medical treatment for my child. In case of emergency, your child will be taken to the nearest medical facility.
**Parent/Guardian Signature: _____Date_____**

I grant permission for generic forms of Tylenol or Advil or Tums to be administered to my child.

**Parent/Guardian Signature: _____Date_____**

**If your child has a life threatening allergy or a serious medical condition that may require emergency care or special procedures at school, please telephone school nurse directly prior to beginning of the school year, at time student enrolls, or as soon as diagnosis is made so plans for care can be developed.**

| **Student Allergies** | **Chronic Illnesses or Medical Conditions (list)** | **Medications (list) Include medications taken at home** |
|---|---|---|
| Has student been prescribed epinephrine (EpiPen or Twinject) for a life threatening allergy? Y____ N____<br>If yes list allergy: _____<br><br>Other Allergies:_____ | _____<br><br>_____<br><br>_____ | _____<br><br>_____<br><br>_____ |

**Please turn over and fill out reverse side**

# LEBANON PUBLIC SCHOOLS
# ANNUAL HEALTH SUMMARY

School Year 2023-2024

**STUDENT NAME:** _____ **GRADE:**_____

Student's Physician: _____Phone: (____)_____

**Please check the following illnesses or conditions that apply:**

- ☐ Frequent colds
- ☐ Sore throats
- ☐ Ear Infections/hearing impairment
- ☐ Seizure disorder
- ☐ Heart
- ☐ Kidney
- ☐ Diabetes
- ☐ Migraines / frequent headaches
- ☐ Other _____
- ☐ Asthma ↴

**For asthma only - If checked, please rate severity level**

☐ mild intermittent ☐ mild persistent
☐ exercise induced ☐ severe persistent

- ☐ Bone Fractures
- ☐ Dislocations/Sprains
- ☐ Scoliosis
- ☐ Weight Problems
- ☐ Recent Surgery/hospitalization
- ☐ Concussion/Head injuries
- ☐ Frequent nosebleeds
- ☐ High blood pressure
- ☐ Skin conditions

**Allergic to:**

- ☐ Animals
- ☐ Drugs
- ☐ Foods_____
- ☐ Milk, Milk products
- ☐ Bee stings
- ☐ Environmental allergies (dust, pollen, grass, etc)
- ☐ Other Allergies

Epinephrine prescribed? (Y___ N____) If yes, list allergy _____

Please explain any conditions checked above:

_____

_____

Is there any other condition pertaining to your child's health you would like to bring to the attention of the school nurse? (Please include any major health changes in last year.)

_____

_____

- Has your child had a tetanus booster in the past year? Y_____N_____ If yes, date_____
- Does your child wear glasses or contacts? Y_____N_____ for Distance ____ Reading ____

Will your child need to take medication at school. Y_____ N_____ List med._____

Connecticut State Law requires a written medication order signed by an authorized prescriber and parent/guardian be submitted for any medication administered at school or any medication authorized to be self-carried by student (inhalers & Epinephrine by older students). Contact school nurse for more information, or if forms are needed.

**I have reviewed the above information and completed it to the best of my knowledge.**

Parent/Guardian Signature_____ Date_____