SCHOOL CITY OF WHITING
MEDICAL HISTORY/EMERGENCY AUTHORIZATION
SCHOOL YEAR
2020-2021

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_____ ___Urinary/kidney problems_____
___Lung Problems _____ ___ Blood Disorders _____
___Headaches_____ ___ Gastrointestinal problems _____
___Skin conditions _____ ___ 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 only if the health condition may impact classroom achievement or to maintain the health and well-being of the student. Information is only 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**