LEBANON PUBLIC SCHOOLS
Lebanon Middle School
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STUDENT EMERGENCY INFORMATION 2020-2021

STUDENT NAME: ______________________________ GRADE (2020-2021)__________
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____ If yes list allergy: __________ Other Allergies: __________	__________ __________ __________	__________ __________ __________

Please turn over and fill out reverse side

LEBANON PUBLIC SCHOOLS
ANNUAL HEALTH SUMMARY

School Year 2020-2021

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.)

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- 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____________