2020 – 2021 Wilmington Area School District Health Emergency Information Form

Name M F Grade/Teacher\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_

 (Last) (First) (Middle) Sex

##  Custody Papers On File – Date

## Father’s Information Mother’s Information Mrs. Ms. Miss

Name Name Last First M.I. Last First M.I.

Address Address

City City

State Zip State Zip

Home Telephone Home Telephone

Cellular Telephone Cellular Telephone

### Employer Employer

Employer’s Address Employer’s Address

Work Telephone ( ) Work Telephone ( )

### Living with: Father Mother Both Other

Step Parent:

**Parent’s e-mail address** (if desired)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

###

When there is an emergency we always try to contact the parent first. However, please list names, addresses and phone numbers of two relatives, friends or neighbors we might call in case we cannot contact the parent. Indicate their relationship to the student.

## 1. Emergency Contact Person 2. Emergency Contact Person

Relationship Relationship

Name Name Last First M.I. Last First M.I.

Address Address

City City

State Zip State Zip

Home Telephone Home Telephone

Cellular Telephone Cellular Telephone

Family Physician Telephone

Family Dentist Telephone

Do you have a hospital preference: Yes \_\_\_\_\_\_ No\_\_\_\_\_\_\_\_, If yes where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INDICATE MEDICATIONS THAT CAN BE GIVEN TO YOUR CHILD DURING SCHOOL BY THE NURSE:**

***□* BENADRYL(ALLERGIC REACTIONS) *□* TYLENOL/ACETAMINOPHEN *□* IBUPROFEN *□* TUMS**

 ***□* COUGH DROPS *□* ORAJEL *□* ANTIBIOTIC OINTMENT**

Does your child have any medical conditions that the school nurse should be aware of (such as asthma, seizures, heart condition, ADD/ADHD)? *□* YES *□* NO

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have allergies?

Medication: *□* NO *□* YES MEDICATION NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ REACTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pollens/molds/spores: *□* NO *□* YES REACTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food: *□* NO *□* YES FOOD NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REACTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plants: *□* NO *□* YES REACTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insect Stings: *□* NO *□* YES REACTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does child have an EpiPen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child has:

Contacts *□*  Glasses *□* Hearing Aid *□* Orthodontic *□* Braces/Appliances *□* Prosthesis *□*

Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there a medical reason that your child will not be wearing a mask? Yes *□* No *□***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any medications that your child is currently taking. Include the reason for the medication.**

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| --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **REASON** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Has your child had any other illness, accident, or broken bones? *□*Yes *□* No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has your child ever been hospitalized or had an operation? *□*Yes *□*No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Does your child have any dietary restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **WHEN** | **NAME OF HOSPITAL** | **REASON** |
|  |  |  |
|  |  |  |

**Has your child had any of the following? Give details.**

|  |
| --- |
| **Speech problems** |
| **Vision/ Eye Problems** |
| **Hearing/ Ear Problems** |
| **Emotional/ Behavioral Problems**  |
| **Physical Disability or other limitations on physical activities**  |

**Please list other children in the family.**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ Grade \_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ Grade \_\_\_**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ Grade \_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ Grade \_\_\_**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ Grade \_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_ Grade \_\_\_**

**Parent Statement (Must be signed by parent/guardian)**

* By signing below, I acknowledge that I have read the information on the reverse side, have made corrections as necessary, and give permission for the school nurse to administer medications checked on the front of this form.
* Parental permission is not required for mandated health screenings, therefore by signing below, I understand my child will receive the health screenings as mandated by the School Health Services of the Wilmington School District. Health Screenings are Height, Weight, Vision, Hearing, and Scoliosis as listed in The Wilmington Area School District Handbook.
* I agree to notify the school district with any medical changes.
* I hereby authorize you, in the event of an emergency, that is, when you are unable to reach me for authorization or when circumstances require immediate action, to proceed according to good medical practice with treatment of my daughter/son. Also authorize the hospital attending physician, or other health care specialist administering the treatment to release pertinent information to the insurance company assuming coverage for the same.
* I understand that unless otherwise notified, the school nurse will share this information on a confidential basis with administrators, professional personnel, and support staff members having direct contact with your child to ensure that his/her health and safety is protected.
* By signing below, I give Wilmington Area School Nurse permission to contact our medical provider/dentist concerning medical needs of my child and give permission for our medical provider/dentist permission to discuss this need with the Wilmington school nurse for this school year. I may rescind this in writing at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature Date**

 **09/01/20**

**Please read and follow the medication administration policy as outlined in the Wilmington Area School District Handbook. Students may NOT keep any type of medication, prescription or nonprescription on their person, in backpacks, lunch boxes, purses or lockers.**