LARAWAY C. C. S. D. 70-C
CONFIDENTIAL EMERGENCY HEALTH INFORMATION
From the Desk of the School Nurse

Please complete BOTH sides of this form and return by mid-August

Name: _____ Birthdate: _____ Sex: M/ F
Last First MI (circle)

School: _____ Grade: _____ Teacher: _____ Date: _____

ALERT TO PARENTS: If your child has a serious medical condition*, it is vital that you discuss this with your School Nurse and teacher(s) immediately*. The school **must** know of **LIFE THREATENING** conditions (for example asthma, diabetes, nut/insect allergies with anaphylaxis) prior to the start of school.

In order to provide a safe and healthy environment for your child this information will be accessible to the following people: School Nurse, your child's teacher, office manager, personnel responsible for health room coverage and emergency medical personnel.

A. Medical History: Check the ones that apply to your child and describe under the comment section.

_____ ADD/ADHD
_____ Anxiety/Panic attack
_____ Asthma
_____ Bee Sting allergy
_____ Bowel problem
_____ Cerebral Palsy
_____ Diabetes
_____ Color Blindness
_____ Epi-Pen
_____ Emotional Concerns
_____ Headaches
_____ Hearing Problem
_____ Heart Condition
_____ Kidney/urinary problems
_____ Muscle Disorder
_____ Neurological Concern
_____ Orthopedic problem
_____ Seizures
_____ Vision problems
_____ Other: _____ (explain)
_____ PE activity
Limited _____
Not Limited _____
Explain:
_____
_____

Comments: _____

B. ALLERGIES: List allergies your child has that may cause a problem at school:

Cause of the allergy: _____ Treatment: _____

Cause of the allergy: _____ Treatment: _____

C. MEDICATION: (Include prescription, over-the-counter and herbal medication.)

	Name	Used to treat	Taken at school?
1)	_____	_____	Yes ☐ No ☐
2)	_____	_____	Yes ☐ No ☐
3)	_____	_____	Yes ☐ No ☐

Before medication of any kind can be administered at school, a medication administration form, available in the office, must be completed by parent and physician and kept on file.

D. List any other operations, injuries, hospitalizations, Give dates: _____
_____

E. Does your student wear contact lens? _____ Glasses? _____

F. Name of Physician: _____ _____ **Phone:** _____

Name of Dentist: _____ _____ **Phone:** _____

(Over)

G. Parents name: _____ _____
(Mother) (Father)

Home Phone: _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

Home address: _____
City/Zip:
Email:

Student lives with: Mother: _____ Father: _____ both parents_____
Other: _____