School Year:_____ **STUDENT HEALTH EMERGENCY CARD** **YOG:**_____

Student's Full Legal Name: _____
Last First Middle

Address: _____

Date of Birth: _____ Gender: F / M / N Grade: _____ Teacher/Counselor: _____

Lives with: _____Both Parents ____Guardian ____Mother ____Father _____ Other Specify _____

Names & Ages of Siblings: _____

Parent (1)/Guardian Name: _____
Last First

Address: *(If not the same as above)*_____

Place of Employment: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Parent (2)/Guardian Name: _____
Last First

Address: *(If not the same as above)*_____

Place of Employment: _____

Home Phone: _____ Work Phone: _____

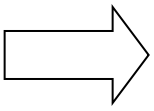
Cell Phone: E-Mail:

Name of others who will assume responsibility/transportation:

Name	Home Phone	Cell Phone	Work Phone
Name	Home Phone	Cell Phone	Work Phone
Name	Home Phone	Cell Phone	Work Phone

Restraining Orders – Please indicate if there are any parental restrictions (i.e. court ordered restraining orders). Copies of court documents should be supplied to the Principal's office. It is the responsibility of the parent to supply the school with renewed court orders if they have expired. **Yes/No**

OVER



In case of an emergency, the school will attempt to contact parent/guardian before calling EMS/First Responders. Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name:_____Phone:_____

Dentist Name:_____Phone:_____

Does your child have health insurance? Y / N

Health Insurance Co.:_____Policy No:_____

Please check all medical issues that are applicable to your child:

_____Heart Condition _____Diabetes _____Asthma _____Depression
_____Seizure Disorder _____Migraines _____ADD/ADHD _____Other
Specify: _____
Recent illness or injury: _____
List all **medications** that your child takes: _____
_____

Allergies: _____
Please specify – food, insects, medications, environment, etc.
Has Epi Pen been prescribed? ___ Yes ___No Has Inhaler been prescribed? ___Yes ___No

_____Hearing problems (specify): _____Left Ear _____Right Ear ___Hearing Aid
_____Vision Problems (specify): _____Wears Glasses (Circle: Distant or Near) _____Contacts

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

I give my permission for the school nurse to perform the following services for my child:

1. Administer any physician prescribed medications for which an official order has been received by the school nurse.
2. Share any of my child's health information and/or related issues with appropriate school staff, primary care physician, health care specialists, dentist, or first responders i.e., EMT's
3. I give permission for my child to be given the below over-the-counter medications (or generic equivalent) if needed while at school. The medication doses to be administered as per package directions and according to School Physician orders. I have **CROSSED off** any medications that I **do not** want my child to have.

Medication List:

Aquaphor	Caladryl Lotion (Anti-itch lotion)	Hydrocortisone Cream
Acetaminophen (Tylenol)	Cough Drops/Throat Lozenges	Ibuprofen (Motrin, Advil)
Bacitracin Ointment	Diphenhydramine (Benadryl)	Orajel
Benadryl Cream	Over the Counter eye drops	Tums/Antacid tabs

Age: _____ Weight: _____

Please *sign* & return this form to the School Nurse _____
Parent/Guardian Signature

(revised 1/30/19) **Date:**_____