Hartford High School – Nurse's Office School Year 2015- 2016

STUDENT EMERGENCY INFORMATION

STUDENT NAME: _____ Date of Birth: _____

Physical address: _____ Home phone: _____

Mailing address: _____ Cell phone: _____

1st contact's name: _____ Place of employment: _____

Relationship to student: _____ Work hours: _____ Work phone: _____

2nd contact's name: _____ Place of employment: _____

Relationship to student: _____ Work hours: _____ Work phone: _____

Parent/guardian e-mail address: _____

Please list two nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached.

1. Name: Home phone: Work phone:

2. Name: Home phone: Work phone:

Student's health problems (i.e. illness, disability, etc.) _____

_____

Allergies: _____

Child's doctor: _____ Telephone: _____ Date last seen: _____

Child's dentist: _____ Telephone: _____ Date last seen: _____

Do you have health insurance? Yes ____ No ____ Name of insurance (i.e. BC/BS, Dr. Dynasaur, Medicaid) _____

Do you have dental insurance? Yes ____ No ____ Name of insurance (i.e. Delta, Dr. Dynasaur, Medicaid) _____

If no, would you like information on health insurance? Yes _____ No _____

Medication taken by your child on a regular basis:

Drug name: _____ Dosage: _____ Frequency: _____

Drug name: _____ Dosage: _____ Frequency: _____

In case of a significant accident or illness, the school will contact me. If the school is not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense. I understand that the school nurse may occasionally need to contact my child's physician/dentist regarding immunizations, medications, or other health issues. I grant permission for my child's physician/dentist and the school nurse to exchange educationally pertinent medical information which they deem to be in the best interest of my child.

Parent/guardian signature: _____ Date: _____

I authorize the school nurse to give my child: Tylenol Ibuprofen Tums for minor aches/pains

PLEASE NOTE: Students are NOT allowed to carry either prescription or over-the-counter medication (except for cough/sore throat drops). All medications must be brought to the nurse's office in the original medication bottle.

Parent/guardian signature: _____ Date: _____