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

STUDENT EMERGENCY INFORMATION

STUDENT NAME: _____ Date of Birth: _____

Please update all contact information in Infinite Campus.

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.) _____

_____

Has a doctor, nurse or other health professional EVER said that your child has asthma? Yes___No__Don't know/not sure____

If yes, does your child STILL have asthma? Yes___No___Don't know/not sure___

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: _____