

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

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 <input type="checkbox"/> No <input type="checkbox"/>
2) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
3) _____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 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: _____