Student I.D. # _____ Home Room _____ YOG _____

STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Please complete the following information below and return to school immediately. Contact school nurse if assistance is needed to complete form. All communications will be confidential.

Student's Name _____ **Grade** _____ ☐ **Male** ☐ **Female**

Street Address _____ Town _____ Zip Code _____

Home Phone _____ Cell _____

Date of Birth _____ Primary Language _____

Name of Parent 1/Guardian _____ **Employer** _____

Home Address _____ Town _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Name of Parent 2/Guardian _____ **Employer** _____

Home Address _____ Town _____ Zip Code _____

Home Phone _____ Work _____ Cell _____

Name/Grade of sisters/brothers in school building _____

_____

Please indicate names of others who will assume responsibility and provide transportation for your student in case of illness/injury/emergency evacuation:

Name _____ Relationship _____

Daytime Phone _____

Name _____ Relationship _____

Daytime Phone _____

Please list all medications that your child takes: _____

_____

In case of medical emergency, the school will attempt to contact parent/guardian before calling student's primary care provider. Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name_____ Telephone _____

Preferred Hospital_____ Telephone _____

Dentist Name_____ Telephone _____

Does your child have Health Insurance? ___ Yes ___ No

Health Insurance Company_____

Policy Number _____

Please check the following that pertain to your child:

☐ Heart Condition ☐ Diabetes ☐ Asthma ☐ Seizure Disorder ☐ ADD/ADHD ☐ Migraines

☐ Depression ☐ Other; Specify: _____

☐ Allergies: To what (ex: food, insects, medication): _____

Does your child have hearing problems? ☐ Yes ☐ No If yes, ☐ Left ear ☐ Right ear ☐ Hearing Aids

Does your child have vision problems? ☐ Yes ☐ No If yes, ☐ wears glasses ☐ contact lenses

I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.

Parent/Guardian Signature_____ **Date** _____

Non-Aspirin Permission (*must* be signed for administration of non-aspirin)

I give permission for _____ **to receive non-aspirin.**
Student's name

Parent/Guardian Signature_____ **Date**_____

Medications: Please note SVTHS must receive the medication forms signed by the primary care or prescribing doctor for any medications the student may need to take during school hours. The documents are available on the web page at www.shawsheentech.org Students may NOT carry medications during the school day.