Haverhill Student Health and Emergency Information Form

Complete the following information and return to school immediately. Contact school nurse if assistance is needed to complete form.

Student's Name: _____
(Last Name) (First Name) (Full Middle Name) (Grade)

Address _____ Sex _____

D.O.B. _____ Place of Birth _____ Primary Language _____

Mother/Guardian/Other _____ Address _____

Phone: Home _____ Cell _____ Work _____

Father/Guardian/Other _____ Address _____

Phone: Home _____ Cell _____ Work _____

List all the Name of Medication your child takes The Dose How often and why they are taking this medication

_____

_____

_____

_____

_____

_____

_____

In case of Emergency, the school will attempt to contact parent/guardian. In the event that we are unable to contact you, your child will be transported by Ambulance to the nearest hospital accompanied by a responsible adult.

Physician Name _____ Phone Number (_____) _____

Dentist Name _____ Phone Number (_____) _____

Please check all that apply to your child

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

☐ Other (Specify) _____

☐ Hospitalization/Surgeries (Specify) _____

☐ Allergies (food, insects, medication, environment)(Specify) _____

☐ Hearing Problems (Specify) Left ear _____ Right ear _____ Hearing Aids _____

☐ Vision Problems (Specify) Wears Eyeglasses _____ Contact Lenses _____ Preferential Seating _____

☐ Dental Problems _____ ☐ Postural (back Problems) _____ ☐ Physical Limitations (Specify) _____

I give the School Nurse Permission to administer the following <u>Over the Counter Medication</u> in accordance with the established protocols. Tums will be administered to students age 11 and over.

☐ **Ibuprofen/ Advil/Motrin** ☐ **Tylenol/Acetaminophen** ☐ **Oragel** ☐ **Tums**

☐ **Antibiotic Ointment** ☐ **Hydrocortisone cream** ☐ **Burn Gel** ☐ **Caladryl Lotion**

I give permission to the School Nurse to share information relevant to my child's health condition and medication with appropriate school personnel needed to meet my child's health and safety needs.

Signature _____ Date _____

Please return to the nurse's office once signed. Thank you!