

2009/2010 ANNUAL EMERGENCY MEDICAL INFORMATION

Student's Name: _____ Birth Date: _____ Sex: _____ School/Grade/ID #: _____

Last First Middle
Month/Day/Year
M/F

Home Address: _____ City: _____ Zip: _____

Father's Name: _____ Phone: Home _____ Work _____ Cell _____

Mother's Name: _____ Phone: Home _____ Work _____ Cell _____

Physician Name: _____ Phone # _____

NOTE: The following persons will be asked to act in your behalf if we are unable to reach you.

Emergency Contact 1: _____ Phone # _____ Relationship: _____

Name
Work/Home/Cell

Emergency Contact 2: _____ Phone # _____ Relationship: _____

Name
Work/Home/Cell

HEALTH HISTORY

The school nurse has permission to share health information concerning my child with appropriate members of the educational team for use in meeting the health and educational needs of the student. This will be done only on a "need to know" basis, in a confidential manner. This consent will be valid for the duration of one year and may be rescinded by the consenting party at any time. PARENT ACCEPTS RESPONSIBILITY OF NOTIFYING SCHOOL NURSE OF ANY CHANGES IN INFORMATION AFTER THIS DATE.

YES _____ NO _____ Parent/Guardian Signature: _____ Date: _____

Middle or High School Student Signature: _____ Date: _____

	Circle One	Comments/Please Be Specific		Circle One	Comments/Please Be Specific
Bone/Joint problems/Injury/Scoliosis?	Yes No		Heart problem/Heart murmur?	Yes No	
Diabetes?	Yes No		Neurological/Muscular Problems?	Yes No	
Diagnosis of asthma? Medication type?	Yes No		Seizures? What are they like?	Yes No	
Ear/Hearing problems?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB Skin test positive (Past or Present)?	Yes* No	*Refer positive responses to the local health department
Dizziness/shortness of breath or chest pain with exercise?	Yes No		Hospitalizations or Surgery within the last twelve (12) months? When? What For?	Yes No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain	Yes No		Chronic Headache / History of Migraines? List medication or treatment.	Yes No	
Diagnosis of ADHD/Emotional Concerns? Medications? Who is prescribing doctor?	Yes No		Medication: (please list all medications administered daily and/or on an as-needed basis)		
Bowel or Bladder problems?	Yes No		Dental? <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other Last Exam _____		
Other concerns or known diagnosis?	Yes No		Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last Exam _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading, color blindness)		
Allergies (Food, Drug, Insect, Other) IF LIFE THREATENING CONDITION ALSO CONTACT YOUR SCHOOL NURSE!					

