SCHOOL HEALTH EMERGENCY FORM

Last Name _____, **First Name** _____ **MI** ___ **Home Telephone Number** _____ **Date of Birth** _____ **Grade** _____

Address: _____ **Zip Code** _____
Social Security Number: _____ **Sex (M/F)** _____
Child Lives With: ___ **Both Parents** ___ **Mother** ___ **Father** ___ **Joint Custody** ___ **Other:** _____
Previous School Attended (if applicable): _____

Mom's Name _____
Mom's Work # _____ **Ext.** _____
Work Hours _____
Mom's Cell Phone _____
Mom's Beeper # _____

Dad's Name _____
Dad's Work # _____ **Ext.** _____
Work Hours _____
Dad's Cell Phone _____
Dad's Beeper # _____

People that can be back-up in emergency or illness when unable to contact parents:
_____ **(Relationship** _____**) Phone #**_____ **or** _____
_____ **(Relationship** _____**) Phone #**_____ **or** _____
_____ **(Relationship** _____**) Phone #**_____ **or** _____
Physician _____ **Phone #** _____ **Dentist** _____ **Phone #** _____

HEALTH HISTORY (Please check ( ) those that apply):
ALLERGIES: _____
(Please get orders from your physician (such as epi-pen) when needed.)

	Describe Allergic Reaction
Medication _____	_____
Food _____	_____
Bee Sting _____	_____
Environmental _____	_____
Has Epinephrine/Epi-Pen been prescribed:	**____ Yes ____ No**
Other _____	_____

BEHAVORIAL CONCERNS:
____ **Asthma: Triggers** _____
____ **Attention Deficit Disorder (ADD or ADHD) Treatment** _____
____ **Bleeding Disorders or Prolonged Bleeding** _____
Treatment of Bleeding Disorder_____
____ **Chickenpox ____ Yes Date** _____ **____ No**
____ **Diabetes: Insulin** _____ **Diet** _____
____ **Ear Infections: Frequency** _____ **Tube Placement** _____ **Still In Place** _____
____ **Hearing Problems** _____
____ **Hospitalization: Date** _____ **Reason**_____
____ **Surgeries: Date** _____ **Type of Surgery** _____
____ **Muscular Disorder**_____
____ **Neurological Disorder** _____
____ **Psychological Disorders/Diagnosed** _____
____ **Scoliosis: Wears Brace** _____ **Other Treatment** _____
____ **Seizures or Epilepsy: Type** _____ **Any precautions needed @ school** _____
Please explain _____ **Treatment** _____
____ **Speech Problems** _____ **Therapy** _____ **Still in Therapy** _____
____ **Vision Problems** _____ **Glasses** _____ **Contacts** _____
____ **Other Health Problems (not listed)** _____
_____
____ **On Any Medications: @ Home** _____
@ School_____

OVER

Does your child have a health problem that would prevent full participation in school or physical education program?
_____ No _____ Yes If so, why?_____
If so, please provide note from child's pediatrician.

Does your child need preferential seating at school?
_____ No _____ Yes If so, why? _____

Do you anticipate any major problems with adjustment?
_____ No _____Yes Please explain _____

If you child develops an illness throughout the school year, please write or call
Our Lady of Grace School
18310 Middletown Road
Parkton, MD 21120
(410) 329-6956

Would you like to have a conference with the School Nurse? _____

Medication Policy Review: All medications (prescription and non-prescription)

- requires medication orders from a physician for EACH school year
- prescription medications must be in a prescription labeled bottle
- non-prescription medications must be in a non-prescription labeled container
- parents need to pick up the medications at the end of the school year

If joint custody, please put 2nd address here:

Name of Parent _____ Home Telephone No. _____

Address _____

Child usually sees this parent on _____ (days).

Any special instructions? _____

_____

Name of Person Authorized to Pick Up Child (daily) _____
(Last) (First) (Relationship to Child)

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible representative of OLGS to have your child transported to that hospital.

_____ _____
Parent's Signature Date

What type of Health Insurance do you have? Private ____ HMO ____ Med. Asst. ____ None ____

Parent's Signature _____ Date _____