SCHOOL HEALTH EMERGENCY FORM
School Year _____-_____

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

Address: _____ Zip Code _____
Sex (M/F) _____
Child Lives With: Both Parents _____ , Mother_____, Father_____, Joint Custody_____ Other: _____

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

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

List three emergency contact persons for back-up when unable to contact parents:
_____ (Relationship _____) Phone #_____Cell _____
_____ (Relationship _____) Phone #_____Cell_____
_____ (Relationship _____) Phone #_____Cell _____

Physician _____ Phone # _____ Dentist _____ Phone # _____

<u>HEALTH HISTORY</u> (Please check ___ those that apply):
ALLERGIES: Describe Allergic Reaction
Medication _____ _____
Food items _____ _____
Bee Sting _____ _____
Environmental _____ _____
Has Epinephrine/Epi-Pen been prescribed: ____ Yes ____ No
Other - _____ _____

HEALTH STATUS:
____ Asthma: Triggers_____, Treatment_____
____ Attention Deficit Disorder (ADD or ADHD) , Treatment _____
____ Bleeding Disorders _____ Treatment_____
____ Chickenpox ____ Yes, Date _____ ____ No
____ Diabetes: Insulin _____ Dietary Restrictions_____
____ Ear Infections: Frequency _____ Tubes R____, L_____ Still In Place _____
____ Hearing Deficits:_____R_____L_____
____ Hospitalization: Date _____ Reason_____
____ Surgeries: Date _____ Type of Surgery _____
____ Muscular Disorder_____
____ Neurological Disorder _____
____ Psychological Disorders/Diagnosis _____
____ Skeletal/Orthopedic Disorder: _____
____ Seizures or Epilepsy: Type _____ Special precautions needed @ school _____
Please explain _____ Treatment _____
____ Speech Problems _____ Therapy _____Current Therapy _____
____ Vision Problems _____ Glasses _____Reading Only_____ Contacts _____
____ Other Health Problems (not listed) _____
_____
____ Current 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 pharmacy labeled bottle. Request school bottle when filled.
- Non-Prescription medications must be in the original container, labeled with student's name and grade.
- Parents /Guardian must deliver and pick up medications administered at school.

If Joint Custody, please list personal data here:

Name of Parent _____ Home Phone-_____Cell_____

Address _____

Child usually sees this parent on _____ (days).

Special instructions: _____

_____

Name of Person Authorized for dismissal pick up _____
(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

Name of Health Insurance Plan _____ ID Number_____
Check one: Private ____ HMO ____ PPO____ Med. Asst. ____ No Insurance ____

Parent's Signature _____ Date _____