APPENDIX #5230

Family/Student Health and Emergency Information

List Names of Students:

_____ (last name/first name) _____ (last name/first name) _____ (last name/first name)

Parent/Guardian #1_____ Home Phone _____
Address_____ Cell Phone _____
Employment_____ Work Phone_____

Parent/Guardian #2 _____ Home Phone _____
Address_____ Cell Phone _____
Employment_____ Work Phone_____

Persons to contact if parent/guardians are not available:

Name:_____ Relationship:_____ Phone: _____

In the event of an emergency (earthquake or other disaster) release my children to (complete only if different from the above):

Name:_____ Relationship:_____ Phone: _____

Family Doctor_____ Phone_____
Family Dentist_____ Phone_____
Hospital Preference_____ Phone_____
Health Insurance: ☐ Private/Group ☐ Medicaid ☐ No Health Insurance

Financial assistance is available, for those who qualify, for dental and/or eye care, shoes and immunizations. If you would like more information on this, please contact the school administrator/principal. **The school is required to have current and complete immunization records on each student by the first day of school.** Vision and hearing screenings will be performed annually. Scoliosis (curved spine) screenings will be performed during the fall of each school year for both boys and girls in grades 6 through 8. If you do not want your child screened, please notify the school.

The school will never dispense internal medication at the request of a student. **No aspirin/Tylenol will be given out.** In response to parent/guardian request, the school will ensure that medication is clearly labeled, be stored and dispensed by a responsible adult. Often this request is a temporary one. If you wish to request this service on a regular basis, please explain:

_____

The school will assist students who have minor accidents or ailments, by using ordinary external supplies such as bandages, antiseptic solution, adhesive tape, cold packs, etc. If you do not wish any of these supplies used for your child, please explain:

_____

With parent permission, the school will administer emergency medication (e.g., EpiPen, Narcan, glycogen shot or spray) when needed, if such medications are maintained by the school.

Authorization for School Officials in Case of Emergency — I authorize school officials to secure emergency treatment if I cannot be reached. I will assume responsibility for expenses incurred. Parent/guardian, add your initials by each student's name on the back.

_____ Parent/Guardian Name (please print) _____ Parent/Guardian Signature _____ Date

List students from oldest to youngest:

Student's Name ________________________ ________________________ ________________ ___________ ___________
(Last) (First) (Middle) (Age) (Grade)

Birthdate (mm/dd/yyyy):_________ / _________ / _________ Social Security Number:_________ - _________-_________

List health conditions or disabilities ____

List medications your child is allergic to ____

Other allergies (food, seasonal, band-aids, other) ____

Medications taken routinely ______________________________ as needed ______________________________

Any vision/hearing problems (wears glasses, contacts, hearing aid)? ☐ Yes ☐ No

Explain: ____

____

Physical exam in the last two years? ☐ Yes ☐ No

Dental exam in the last year? ☐ Yes ☐ No

Immunization or boosters in the last year? ☐ Yes ☐ No

__________________________ (Type) ___________ (Date)

Student's Name ________________________ ________________________ ________________ ___________ ___________
(Last) (First) (Middle) (Age) (Grade)

Birthdate (mm/dd/yyyy):_________ / _________ / _________ Social Security Number:_________ - _________-_________

List health conditions or disabilities ____

List medications your child is allergic to ____

Other allergies (food, seasonal, band-aids, other) ____

Medications taken routinely ______________________________ as needed ______________________________

Any vision/hearing problems (wears glasses, contacts, hearing aid)? ☐ Yes ☐ No

Explain: ____

____

Physical exam in the last two years? ☐ Yes ☐ No

Dental exam in the last year? ☐ Yes ☐ No

Immunization or boosters in the last year? ☐ Yes ☐ No

__________________________ (Type) ___________ (Date)

Student's Name ________________________ ________________________ ________________ ___________ ___________
(Last) (First) (Middle) (Age) (Grade)

Birthdate (mm/dd/yyyy):_________ / _________ / _________ Social Security Number:_________ - _________-_________

List health conditions or disabilities ____

List medications your child is allergic to ____

Other allergies (food, seasonal, band-aids, other) ____

Medications taken routinely ______________________________ as needed ______________________________

Any vision/hearing problems (wears glasses, contacts, hearing aid)? ☐ Yes ☐ No

Explain: ____

____

Physical exam in the last two years? ☐ Yes ☐ No

Dental exam in the last year? ☐ Yes ☐ No

Immunization or boosters in the last year? ☐ Yes ☐ No

__________________________ (Type) ___________ (Date)