

Hartford High School Health Services Office
STUDENT EMERGENCY INFORMATION: 2019/2020 School Year

STUDENT: Last Name _____ First Name _____ D.O.B _____ Grade _____

Student Lives With _____ Parent to Contact 1st in Emergency _____

Address _____ Address _____

Phone #s: Home _____ Phone #s: Home _____

Work _____ Cell _____ Work _____ Cell _____

Email _____ Email _____

Please list two nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached.

1. Name _____ Home Phone _____ Work/Cell Phone _____

2. Name _____ Home Phone _____ Work/Cell Phone _____

Student's health problems (i.e. illness, disability, etc.): _____

Allergies: _____

Medication taken by the student on a regular basis (continue on the back of this form if needed):

Drug name: _____ Dosage: _____ Frequency: _____

Drug name: _____ Dosage: _____ Frequency: _____

Has a doctor or healthcare professional EVER said that your child has asthma? Yes ___ No ___ Don't know/Not sure ___

If yes, does your child STILL have asthma? Yes ___ No ___ Don't know/Not sure ___

Child's doctor: _____ Telephone: _____ Date of last physical exam: _____

Child's dentist: _____ Telephone: _____ Date of last routine visit: _____

Do you have health insurance? Yes ___ No ___ If yes, name of insurance carrier _____

Do you have dental insurance? Yes ___ No ___ If yes, name of insurance carrier _____

If no, would you like information on health and/or dental insurance? Yes ___ No ___

In case of a significant accident or illness, I request the school to contact me. If not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense. I understand that the school nurse may occasionally need to contact my child's PCP/dentist/optometrist/specialist regarding immunizations, medications, vision or other significant health issues. I grant permission for my child's healthcare provider and the school nurse to exchange educationally pertinent medical information which they deem to be in the best interest of my child.

****Parent/Guardian Signature:** _____ **Date:** _____ ******

I authorize the school nurse to give my child: Acetaminophen (Tylenol) Ibuprofen Tums for minor aches/pains

****Parent/Guardian Signature:** _____ **Date:** _____ ******

Please note students are NOT allowed to carry prescription or over-the-counter medications on their persons (with the exception of certain rescue medications). All medications but be kept in the nurse's office in the original pharmacy/manufacture labeled container.