**Hartford High School Health Services Office**

# STUDENT EMERGENCY INFORMATION: 2020/2021 School Year

STUDENT: Last Name________________________ First Name_______________________ D.O.B______ Grade ______

Student Lives With ___________________________ Person 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 uninsured, call Vermont Health Connect at 1-855-899-9600 or visit https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

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 (Advil) Antacid (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 person (with the exception of certain rescue medications). All medications must be kept in the nurse's office in the original pharmacy/manufacturer labeled container.