East Allen County Schools
HEALTH SERVICES

STUDENT *EMERGENCY* INFORMATION

To be completed by custodial parent or legal guardian

Bus Walk Parent transport Student drives self
(Circle all that apply)

Student's Name _____ Sex M - F Birth Date _____ Grade _____

Street Address _____ City and Zip _____

Student lives with: ☐ Parents ☐ Father ☐ Mother ☐ Foster/Residential Care ☐ Other _____

***LEGAL GUARDIAN** _____ **Home Email Address** _____

Father's Name _____ Home Phone _____ Cell _____ _____

Place of employment _____ Work Phone _____ Work Email _____

Mother's Name _____ Home Phone _____ Cell _____ _____

Place of employment _____ Work Phone _____ Work Email _____

Family Physician _____ Office Phone _____

Dentist _____ Office Phone _____

IN CASE OF ILLNESS OR EMERGENCY AT SCHOOL, I understand every effort will be made to contact the parent or guardian. *When this fails*, the following person(s) may be contacted to speak on behalf of the parent or guardian concerning this student. **Emergency contacts are family and/or friends** the parent or guardian entrusts with their child**. Emergency contacts** should live a short drive from the school and be available during the school day to pick up sick or injured students. We encourage you to have more than one emergency contact person. If none of the designated contacts can be reached, and a serious medical emergency exists requiring medical treatment beyond what is provided at school to maintain safety and/or life, this student may be transported by EMS to _____ hospital.

#1 Name _____ Phone # _____ Relationship _____

#2 Name _____ Phone # _____ Relationship _____

#3 Name _____ Phone # _____ Relationship _____

COMPLETE REQUESTED HEALTH INFORMATION THAT APPLIES TO THIS STUDENT This information will be on file in the school clinic. All student health information is considered confidential and shared only if the health condition may impede classroom achievement on a "need to know" basis. **ALL medication MUST be supplied to the school by the parent or guardian. The school does NOT STOCK any medication.**

ALLERGIES: ☐ **NO** Known Allergies ☐ **YES** ☐ Milk Allergy ☐ Lactose Intolerant ☐ Other: _____

Describe reaction: _____

Requires medication? ☐ Yes ☐ No Has your child ever had a severe reaction requiring hospitalization? ☐ No ☐ Yes

ASTHMA: ☐ **NO** ☐ **YES:** ☐ Activity Induced ☐ Allergy Induced ☐ Anxiety Induced ☐ Other: _____

On a scale from 1 (very mild) to 10 (severe) rate your child's asthma (circle appropriate number) 1 2 3 4 5 6 7 8 9 10

Asthma control regime _____ Will your child use/carry an inhaler at school? ☐ No ☐ Yes

Students that carry and self-administer inhalers must have a completed **Medication Self-Administration Consent Form** (Hs-5b) on file.

ATTENTION DEFICIT DISORDER: ☐ **NO** ☐ **YES:** ☐ Without Hyperactivity (ADD) ☐ With Hyperactivity (ADHD)

Medication required during school hours? ☐ **NO** ☐ **YES**

DIABETES: ☐ **NO** ☐ **YES:** Age Diagnosed ____ Controlled by: ☐ Diet Only ☐ Diet and Oral Medication ☐ Insulin Dependent

Additional Information _____

~ An **EACS Diabetes Medical Management Plan** MUST be completed by the physician and parent/guardian, contact the school nurse.

EPILEPSY: ☐ **NO** ☐ **YES**: List Type _____ Controlled with _____

How frequent is seizure activity? _____ Known Triggers _____

Describe typical seizure: _____

Vision ☐ No problems ☐ wears glasses ☐ wears contacts

Hearing ☐ No problems ☐ wears aides ☐ Other, explain: _____

List other medical/psychological conditions, disorders, and/or diseases _____

(Use back of form if additional space is needed)

List ALL daily medications (home and school)--dosage, time given, and reason for medication _____

_____

I authorize East Allen County Schools, to copy this form and give to emergency medical personnel in the event of a medical emergency requiring EMS transport.

PARENT/GUARDIAN SIGNATURE_____ Date _____

EACS Hs-9 2016

**** BRING TO REGISTRATION - RETURN THIS FORM TO THE SCHOOL NURSE ****