FRANCIS HOWELL SCHOOL DISTRICT
STUDENT HEALTH/EMERGENCY INFORMATION

This completed form must be emailed, faxed or printed and sent directly to your child's NURSE, this fillable form is not automatically sent to the school. Contact your child's school for the nurse's email or fax number.

STUDENT' S LEGAL NAME

☐ M ☐ F

Last Name First Name Middle Name Gender

Student ID#: _____ Teacher/Grade: _____ Date of Birth: _____
Address: _____ City: _____ Zip:_ _____ Home Phone:_ _____

Student Resides With: _____

Parent / Guardian 1 Name: _____ Work Phone:_ _____
Living in Home? ☐ Yes ☐ No. Has permission to pick up from school? ☐ Yes ☐ No Cell Phone:__ _____

Parent / Guardian 2 Name: _____ Work Phone:_ _____
Living in Home? ☐ Yes ☐ No. Has permission to pick up from school? ☐ Yes ☐ No Cell Phone:_ _____

Physician's Name:_ _____ Phone: _____
Hospital Preference:_ _____

In the event of an EMERGENCY or ILLNESS and parent/guardian cannot be reached, please provide the contact information for two people, who will assume responsibility for your child. In case of a critical emergency, the Administrator or his/her designee will call 911 or appropriate emergency service and the parent/guardian. If the parent/guardian cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parents.

Name:_____Relationship:_____Day Phone:_____

Name:_____Relationship:_____Day Phone:_____

DOES YOUR CHILD HAVE:	NO	YES	SPECIFY	IS YOUR CHILD DIAGNOSED WITH:	NO	YES	SPECIFY
Food Allergies	☐	☐		ADD	☐	☐	
Drug Allergies	☐	☐		ADHD	☐	☐	
Allergy requiring epi-pen	☐	☐		Anxiety	☐	☐	
Asthma	☐	☐		Autism	☐	☐	
Epilepsy/Seizures	☐	☐		Bipolar	☐	☐	
Diabetes	☐	☐		Depression	☐	☐	
Takes Insulin	☐	☐		Emotional Condition	☐	☐	
Heart Condition	☐	☐		Other, please specify:			
Kidney Disease	☐	☐					
Other, please specify:							
				Is your child currently under The care of a mental health Provider?	☐	☐	
				If so, who?			

Has your child had a serious illness/hospitalization? ☐ NO ☐ YES
Specify:

Does your child wear glasses or contacts? ☐ NO ☐ YES Specify:

Does your child wear a hearing aid or cochlear implant? ☐ NO ☐ YES Specify:

Does your child need restrictive PE? ☐ NO ☐ YES (requires physician's written documentation)

Does your child take daily medication? ☐ NO ☐ YES Specify: _____
Will your child require medicine at school? ☐ NO ☐ YES Specify: _____

PRESCRIPTION AND OVER THE COUNTER MEDICATION to be given at school requires a written doctor's order and written parent permission along with the ORIGINAL bottle of medicine.

ELEMENTARY LEVEL: I GIVE PERMISSION for the nurse to administer acetaminophen /Tylenol® or Ibuprofen to my child in the dosage prescribed by the Francis Howell School District physician and per package directions on an "as needed" basis 4 times per school year. **SECONDARY LEVEL**: Acetaminophen/Tylenol® or Ibuprofen 8 times per school year YES ☐ NO ☐

Guardian Name: Relationship: Date:

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☐ By checking this box you are verifying that all of the information filled out on this form is accurate.