STUDENT HEALTH/ EMERGENCY INFORMATION / PERMISSION TO TREAT FORM

CONCORD PUBLIC SCHOOLS

2015-2016

STUDENT NAME_____ **GRADE/ HR**_____

Last First Middle

Address _____

Home Phone_____ Sex _____DOB: _____ Primary Language_____

Please list contacts in order contact should be made: Please list phones numbers in order of preferred contact.

Parent/Guardian/Other _____ Home Address _____

Home / Work/ Cell _____

Home / Work/ Cell _____ Place of Employment _____

Parent/Guardian/Other _____ Home Address _____

Home / Work/ Cell _____

Home / Work/ Cell _____ Place of Employment _____

Name/Grade of siblings in school building _____

Please indicate names of friend/relative/neighbor who will assume responsibility and provide transportation for your student in case of illness/injury/emergency evacuation.

Name _____ Relationship _____ Daytime Phone _____

Name _____ Relationship _____ Daytime Phone _____

Physician Name _____ Phone Number_____ Date of Last Examination _____

Dentist Name _____ Phone Number _____ Date of Last Examination _____

My child is taking medications at this time. YES ____ NO____ PLEASE LIST:_____

Special instructions concerning my child: _____

To better serve your child's medical/physical/emotional/educational/social needs, please check the following that pertain to your child:

___ Heart Condition ___ Diabetes ___ Asthma (Inhaler___) ___ Seizure Disorder ___ ADD/ADHD

___ Migraines ___ Depression ___ Other (Specify) _____

___ Allergies (Current or History of): *To what? (food*, *insects*, *medication, environment*) Specify_____

___ Epi-Pen _____

Does your child have hearing problems: Yes_____ No_____ Left ear _____ Right ear _____ Hearing Aids _____

Vision Problems: Yes_____ No_____ Eyeglasses_____ Contact Lens_____ Preferential Seating _____

PARENTAL CONSENT:

I give permission to the school nurse to administer/apply the following medications according to the approved protocol and guidelines of Concord Public School district. To the best of my knowledge, my child has no allergy/ sensitivity to the below named products. Please complete:

Acetaminophen [Tylenol] YES ____ NO____

Benzocaine (for insect bite/ sting) YES ____ NO____

Bacitracin Ointment (for minor cuts, scrapes and burns) YES ____ NO____

Caladryl Lotion (for itching and pain caused by insect bites/ minor burns/ scrapes/ minor skin rash) YES ____ NO____

Cough Drops (for cough and minor throat irritation, only to be administered in health office) YES ____ NO____

I give permission for the exchange of information between my child's healthcare providers and the school nurse. YES___ NO__

I understand that this information is confidential. However, federal law permits information in the school health records to be shared with school staff on a "need to know" basis, including those who could help in an emergency. In other circumstances, my consent will be required.

Parents Signature _____ Date _____