Student Emergency Information

West Hartford Non-Public
School Health Services

School Year 2018 - 2019

Class / Grade _____

Student Information

Name: _____ M / F Date of Birth: _____
Last First Middle

Student Street Address: _____

City, State and Zip: _____ Home Phone _____

Parent Email:_____ Consent to use for contact: Yes / No

Student Lives With: _____ Primary Language: _____

Parent / Guardian Contact Information

1) Parent Name: _____ Best Contact/ ER Number: _____
Work Number: _____

2) Parent Name: _____ Best Contact / ER Number: _____
Work Number: _____

Please identify which parent should be contacted *first*: 1st _____ or 2nd _____

Does your child go to a location other than home after school: Yes _____ No _____
If yes, please list care provider and contact number:
Name: _____ Contact Number: _____

Others **authorized** to pick your child up from school: _____

Emergency Contacts

List two names of persons who will assume temporary care of your child if you cannot be reached and your child needs to leave school due to an illness.

Name: _____ Contact Number: _____ Relationship: _____

Name: _____ Contact Number: _____ Relationship: _____

Please complete other side for Medical Information

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Student Name:_____ DOB: _____

Known Allergies: _____ Insects _____ Foods _____ Drugs _____ Animals _____ Other

If yes, please explain: _____

- Does your child have an Epipen? Yes _____ No _____

***If yes**, a <u>medical order/action plan and epi pen</u> **must** be submitted to the school nurse*.

- Does your child have asthma or use an inhaler? Yes _____ No _____

***If Yes**, a <u>medical order/action plan and inhaler</u> **must** be submitted to the school nurse*.

- Please list any medications taken at home or school:

  _____

- **Other health concerns/conditions: _____**

  _____

*__Please note__ that __ALL__ medications, <u>including over the counter medications</u>, to be given at school must be prescribed by a MD, Dentist, APRN, PA, Optometrist and Podiatrist. The order must accompany the medication in its __original__ container and be delivered by a parent/adult to the school nurse.

Student's Physician: _____Contact Number: _____

Dentist: _____ Contact Number: _____

Does this student have **Health Insurance**: Yes _____ No _____

*If medically necessary the child will be transported to Connecticut Children's Medical Center unless otherwise noted in writing.

In the event of anaphylaxis, a life-threatening event, the school nurse or, in the absence of the school nurse, a qualified school employee will administer Epinephrine in accordance with the medical orders set forth by the School Medical Advisor and CT PA 14-176, unless written notice by parent opting out is received.
I understand that in the event of a serious injury/illness the school will contact me. If medical transport is required, I give permission for the school to transport the student for medical care as deemed necessary.
I understand, and give permission for the school nurse to provide health services, education, health screenings mandated by the State of Connecticut and to provide routine first aid according to approved medical guidelines and formulary unless written notice by parent is received.

Parent Name (print): _____ Student Name: _____

Parent Signature: _____ Date: _____

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