

Medical and Emergency Info

Please complete the following questions regarding your child. This information is being requested so the school can provide your child with the best possible learning environment. Information provided will be shared with classroom teachers and/or other individuals only as deemed necessary by the school nurse, administration or in the event of an emergency.

Student Name _____ Grade _____

No health issues

Please check box to indicate student has a health concern and explain further in space provided:

- Vision problem - _____
 Wears glasses Wears contacts
If your child wears glasses, when are they to be worn?
 near work far work at all times may be removed for recess/PE
- Hearing problem - left ear right ear both ears
- Migraines
- Seizure disorder (need action plan)–Please describe type of seizure and frequency of occurrence _____

- Heart problems- _____
- Respiratory problems - _____
 Asthma reactive airway disease (RAD) other _____
- Musculoskeletal problem - _____
- Stomach or digestive problems - _____
- Urinary problems - _____
- Bowel problems - _____
- Physical limitations or restrictions (Physician’s note required for PE/recess modifications or exclusions lasting more than 3 days) _____

- Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
- Mental Health Condition - depression bipolar anxiety disorder other
- Allergies - food medication environmental latex other
(Please describe) _____

- Current routine medications (please list) *Any medication that needs to be given by school personnel (prescription, over-the-counter, cough drops, eye drops, etc.) MUST be accompanied by completed OTC Medication Form.*
Medication _____
Dosage _____
Time taken _____

OVER

Please use this space to provide additional information regarding any health concern

Please complete the following information for emergency purposes:

Parent/Guardian name _____ Cell/Home _____
Work place and number _____

Parent/Guardian name _____ Cell/Home _____
Work place and number _____

Family Physician or Pediatrician's Name _____
Phone _____

Other physician whom this student regularly visits _____
Phone _____

In the event my child needs emergency medical care, transport him/her to the nearest hospital. I agree to assume all responsibility and expense, including transportation costs. I authorize the attending physician and hospital to render medical care to my child as necessary. I understand that Illinois law requires ambulances transport to the nearest hospital to insure the patient is stable before transporting to another facility.

NCHS has undesignated stock of Epinephrine, Albuterol and Naloxone. Epinephrine is used to treat severe allergic anaphylaxis. Naloxone is used to reverse opiate overdose. Albuterol is an inhaler used for severe asthma attack. In the event of an emergency, I give NCHS school nurse or other trained personnel permission to administer these life-saving medications.

Signature of Parent or Legal Guardian

Date

Attention Parent or Legal Guardian: If you have any questions, or if you feel any of the information requested is of a sensitive or confidential nature, please contact the school nurse or principal for a private conference.