

Student Health History & Emergency Medical Treatment Consent Form

Student's Name: _____

Date of Birth: _____

Grade: _____

Address: _____

Gender: _____

Emergency Contacts:

Contact Name	Relationship	Contact Phone Numbers
Call 1 st :		Home: _____ Cell: _____ Work: _____
Call 2 nd :		Home: _____ Cell: _____ Work: _____
Call 3 rd :		Home: _____ Cell: _____ Work: _____

Student's Doctor/Healthcare Provider: _____ Phone Number: _____

Insurance Information: _____

(Include Group's Name, ID Number, Group Number and Subscriber)

Indicate if Student has been diagnosed by a Licensed Healthcare Provider with any of the following

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your Licensed Healthcare Provider, and an Emergency Plan prepared by the school must be in place before your child can attend school

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies	☐	☐	List:
Food Allergies	☐	☐	Food(s): ☐ Peanut ☐ Dairy ☐ Eggs ☐ Other: Reaction Rate: ☐ Mild ☐ Moderate ☐ Life-threatening EpiPen Required? ☐ Yes ☐ No
Allergy to Bee Stings	☐	☐	Reaction Rate: ☐ Mild ☐ Moderate ☐ Life-threatening EpiPen Required? ☐ Yes ☐ No
Allergies (Other)	☐	☐	List:
Asthma	☐	☐	Reaction Rate: ☐ Mild ☐ Moderate ☐ Life-threatening Asthma medication taken at home: Medication required at school:
Diabetes	☐	☐	☐ Type 1 (Insulin Dependent) ☐ Type 2 Diabetes medication(s) taken at home:
Seizure Disorder	☐	☐	Type of Seizure: Medication taken:
Neurological Disorder	☐	☐	Specify:
Heart Condition	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
Cancer	☐	☐	Specify: Treatment:
Bowel/Bladder Issues	☐	☐	Specify:
Migraine Headaches	☐	☐	Triggers: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health Behavioral Issues	☐	☐	Specify: Treatment/Medication:
Wearing Glasses/Contacts	☐	☐	☐ Glasses ☐ Contacts Used for: ☐ Distance ☐ Reading
Hearing Loss	☐	☐	☐ Hearing loss Right Ear ☐ Hearing loss Left Ear ☐ Hearing Aid(s)
Other Serious Illness	☐	☐	Specify: Date of Onset:
Serious Injury	☐	☐	Specify: Date(s):
Surgery	☐	☐	Specify: Date(s):
Medication taken at Home (if not already listed)	☐	☐	List:

The information on this form may be shared confidentially with school staff and emergency responders as needed, in the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstances.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____