

HEALTH ROOM EMERGENCY INFORMATION

School Year 20 -20 _____

PLEASE PRINT OR TYPE

Student's Name _____
(Last) (First) (MI)

Address _____ Email: _____
Street City Zip code parent /guardian

Homeroom: _____ DOB: _____ Sex: M ___ F ___ Grade: _____ Age: _____ Bus #: _____

Mother/Guardian's Name: _____ Employer _____

Home Phone #'s _____ Work _____ Cell _____

Father/Guardian's Name: _____ Employer _____

Home Phone #'s _____ Work _____ Cell _____

SIBLINGS WHO ATTEND CHARLES COUNTY PUBLIC SCHOOLS

Name (First and Last) DOB Grade School

Is English the primary language at home? ____ Yes ____ No If no, primary language _____

List at least three neighbors or nearby relatives with transportation who have your permission to assume temporary care of your child **IF YOU CANNOT BE REACHED** or **YOU ARE UNAVAILABLE TO PICK UP YOUR STUDENT WITHIN 30 MINUTES OF NOTIFICATION**

Name	Relationship	Home #	Cell #	Work #

In case of an accident or serious illness, I request the school contact me. I hereby authorize the school to arrange transportation to and treatment of my child at the emergency room of the nearest hospital, or if outside of the county, to the nearest appropriate facility where medical treatment is available.

HEALTH INFORMATION (Note: THE SCHOOL HEALTH PROGRAM TREATS THIS INFORMATION CONFIDENTIALLY)

Drug Allergy(s)	
Medication(s) taken at Home	
Medication(s) taken at School	

PLEASE MAKE SURE THAT YOU LIST AND DISCUSS THE FOLLOWING CONDITIONS AND REACTIONS WITH YOUR CHILD'S SCHOOL NURSE

Food Allergies w/reaction	
Insect Allergies w/reaction	

PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

ADD/ADHD	Dyslexia/Learning Concerns	O.D.D.
Asthma	Eating Concerns	Panic Attacks
Bi-polar	Epilepsy/seizure concerns	Severe Seasonal Allergies
Bladder concerns	Fainting/Blackout spells	Sickle Cell Disease
Bowel concerns	Heart condition	Vision Concerns
Cystic Fibrosis	Hearing Concerns	Other Health Concerns:
Depression	Kidney Concerns	
Developmental Concerns	Migraine Headache	
Diabetes	Orthopedic Concerns	

Child's Physician's Name: _____ Phone #: _____

Signature of Parent or Guardian

Date