Emergency Contact & Health Information Form 2023 - 2024

PLEASE COMPLETE AND EMAIL DEBORAH MULVIHILL, ADMINISTRATIVE COORDINATOR @ dmulvihill@stmichael.net BEFORE MAY 15, 2023.

Student's Name: _____ **Birthdate:** _____ **Gender:** _____ **Grade:** _____

Physician's Name: _____ **Physician's Phone:** _____

Parent/Guardian 1		**Parent/Guardian 2**		**Primary Emer. Contact**	
Relationship		**Relationship**		**Relationship / Phone**	
Email		**Email**		**Secondary Emer. Contact**	
				Relationship / Phone	
Phone	☐ Work ☐ Cell ☐ Home	**Phone**	☐ Work ☐ Cell ☐ Home	***My child CANNOT be released to:***	

CURRENT HEALTH CONDITIONS*: ☐ **Please check here if your child has NO health conditions to report (Fill in the health conditions/concerns that your child has NOW & that may affect your child at school)**

Asthma	**Mental Health Diagnosis** ☐ ADD ☐ ADHD ☐ Other
Severe Allergy/Anaphylaxis* (requiring emergency medication) To what? Do you need medications at school to treat an allergic reaction? ☐ No ***If YES, please contact RN & return Allergy Action Plan to the Health Office with the appropriate medications.** **Allergy to medications: (Please let med & reaction)**	**Hearing Problems:** **Vision Problems: (excluding corrective lenses)** **Neurological / Seizure Disorder:** **Heart/Cardiovascular Condition:** **GI/Bowel Disorder:**
Allergy to foods: (Please list food & reaction)	**Diabetes:**
Allergy to insect bites: (Please list insect & reaction)	**Orthopedic Problem:**
Environmental allergan: (trees, grass, pollen, etc.)	**Urinary/Kidney:**
☐ Headaches ☐ Migraines ☐ Past Concussions **Check those that apply and explain:**	**Recent Operations/Serious injuries:**

In case of serious illness or injury, I give consent for my child, accompanied by school personnel, to be taken to the closest hospital by ambulance and have emergency medical treatment provided there, until I can be contacted. My child is eligible for medical care with the following insurance company and/or preferred hospital. ☐ Yes ☐ No _____

List of Medication needed <u>at home</u>

Name of Medication	Dosage/Frequency	Reason

List of Medication needed <u>at school</u>

Name of Medication	Dosage/Frequency	Reason

A Medication Consent Form must be completed for a student to receive prescription medicine at school. The prescription medication must be clearly labeled prescription bottle with the student's name and instructions as specified by the pharmacy. **This form and the form for students to carry and self-administer Epi-pen and Inhaler are available from the School Nurse.

<u>Parental Permission for Over-the-Counter Medications:</u> **Please check Dosage box to authorize school nurse/staff to give your child the following medications while on campus.**

Over-the-counter medication dispensed per package directions:	Indications:	Dosage (please check)
Acetaminophen (generic Tylenol)	Pain reliever/fever reducer	☐ 36-47 lbs: 160 mg ☐ 72-95 lbs: 480-500 mg ☐ 48-71 lbs: 320 mg ☐ 96lbs +: 500-650 mg
Ibuprofen (generic Advil/Motrin)	Pain reliever/fever reducer	☐ 36-47 lbs: 150 mg ☐ 72-95 lbs: 300 mg ☐ 48-71 lbs: 200 mg ☐ 96lbs +: 400 mg
Antacid (Calcium Carbonate)	Stomach pain/upset stomach	☐ 1 Tablet (400 mg ea) ☐ 2 Tablets (400 mg ea)
Triple antibiotic ointment	Minor scrapes/cuts	☐ As directed
Hydrocortisone 1% lotion	Itching/skin rashes	☐ As directed

PARENT/GUARDIAN NAME _____ **SIGNATURE** _____ **DATE** _____

This form's information will be kept confidential, shared only on a need-to-know basis and used only in an emergency. They will be maintained in a confidential and secure manner, but in a way they can be swiftly accessed when needed.

THE INFORMATION ON THIS FORM IS VERY IMPORTANT FOR THE HEALTH & SAFETY OF YOUR CHILD.
IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL OFFICE OR SCHOOL NURSE IF THERE ARE ANY CHANGES OR UPDATES IN YOUR CHILD'S HEALTH.

THANK YOU!