



**Due by: August 16, 2017**  
(1<sup>st</sup> day of school)

Grade Level: \_\_\_\_\_  
School Year \_\_\_\_\_ - \_\_\_\_\_

**STUDENT INFORMATION & EMERGENCY FORM**

Student's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
(First) (Middle) (Last)

Student's Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Parents' Marital Status: \_\_\_\_\_ Student primarily lives with: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please mark if there has been a change in any of the following since last year (check all that apply):  
 Address  E-mail for: mother / father (circle one)  
 Phone number for: mother / father (circle one)  Other \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(other than parent) (Name) (Relationship) (Phone)

\_\_\_\_\_  
(Name) (Relationship) (Phone)

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Primary method of pick up (Please check ONE):**  carpool  walk-up  extended day

This child may be released **ONLY** to the following persons age 18 or older. (Include **ALL** parents/guardians or designees.)

Name:	Relationship:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Calvary Episcopal Preparatory Student Health History

Student Name \_\_\_\_\_

## CONFIDENTIAL MEDICAL INFORMATION—*Must be completed each year.*

Place a check mark in the box next to any conditions that your child has. Please provide thorough information.

**NO MEDICAL HISTORY OR CONDITIONS**

**Allergies to food** \_\_\_\_\_ Reaction \_\_\_\_\_ Treatment \_\_\_\_\_

**Allergies to medication** \_\_\_\_\_ Reaction \_\_\_\_\_ Treatment \_\_\_\_\_

**Allergies (seasonal)** \_\_\_\_\_ Reaction \_\_\_\_\_ Treatment \_\_\_\_\_

**Allergies (other)** \_\_\_\_\_ Reaction \_\_\_\_\_ Treatment \_\_\_\_\_

**\*\*\*Are any of the above allergies life threatening?** Yes / No (circle one) If yes, please provide an Allergy Action Plan.

**ADD or ADHD (please circle)** Medication: \_\_\_\_\_ Once or Twice daily (circle one)

**Asthma / Respiratory Problems** (circle one) Medication: \_\_\_\_\_ Inhaler at school? Yes / No

**\*\*\*If your child has asthma, please provide an Asthma Action Plan.**

**Auto-immune Disorder** (please explain) \_\_\_\_\_ Medication \_\_\_\_\_

**Blood Disorder** (please explain) \_\_\_\_\_ Medication \_\_\_\_\_

**Diabetes** Type 1 or 2 (circle one) Medication \_\_\_\_\_ Blood sugar checks at school? Yes / No

**\*\*\*Please provide a Diabetes Medical Management Plan for School**

**Eating Disorder** (please explain) \_\_\_\_\_

**Ear Infections (frequent)** Left / Right / Bilateral How often? \_\_\_\_\_

**Heart Condition** \_\_\_\_\_ Medication \_\_\_\_\_ Restrictions \_\_\_\_\_

**Migraines / Frequent Headaches** (please circle) Medication \_\_\_\_\_

**Musculoskeletal Condition** (please explain) \_\_\_\_\_ Medication \_\_\_\_\_

**Neurodevelopmental** (please explain) \_\_\_\_\_

**Nosebleeds (frequent)** How often? \_\_\_\_\_

**Physical Impairments** (please explain) \_\_\_\_\_ Assistance needed \_\_\_\_\_

**Seizures** Type & description \_\_\_\_\_ Medication \_\_\_\_\_

**\*\*\*Please provide a Seizure Action Plan.**

**Stomach Conditions** (please explain) \_\_\_\_\_ Medication \_\_\_\_\_

**Urinary / Kidney / Bowel Conditions** (please explain) \_\_\_\_\_ Medication \_\_\_\_\_

**Other** (please explain) \_\_\_\_\_ Medication \_\_\_\_\_

## IMMUNIZATION RECORDS

**Immunization records or exemptions must be provided at the beginning of the school year.**

**Returning Student**—No changes or new immunizations in the last year.

**Returning Student**—Proof of immunization must be provided for vaccines given in the last year.

**New Student**—Acceptable evidence of vaccination is required at the start of the school year. Documentation of vaccines administered should have the signature or stamp of the physician or his/her designee or public health personnel. An office immunization record generated from a state or local health authority is also acceptable.

### Exemptions from immunizations

**Medical**—must be renewed *every year* and provided to school

**Reasons of Conscience**—must be renewed *every two years* and provided to school. Valid until \_\_\_\_\_

**I UNDERSTAND IN CASE OF EMERGENCY, ILLNESS, OR INJURY TO MY CHILD, the nurse or a school representative will use his/her discretion in following any or all of the procedures listed below:**

1. Provide emergency first aid
2. Communicate with Parent/Guardian/Emergency Contact
3. Contact child's Physician/Dentist for instructions
4. Call 911 for ambulance and/or transport to hospital

In the event reasonable attempts to contact a parent/guardian have been unsuccessful, the undersigned gives consent, authorizing officials at Calvary Episcopal Preparatory to contact directly the persons named on this form as deemed necessary in an emergency for the health of said child. If the named persons cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child, including transfer of the child to any hospital reasonably accessible.

**I also understand I will assume financial responsibility for all medical expenses, medical services, and transportation.**

**I will promptly alert the school of any changes in the emergency information contained on this form.**

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_