CALVARY
EPISCOPAL PREPARATORY

Grade Level: _____

STUDENT INFORMATION & EMERGENCY FORM
2016 – 2017

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: _____

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: _____

This child will be picked up from: □ 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:

CONTINUED ON NEXT PAGE

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** _____