

ARLINGTON CENTRAL SCHOOL DISTRICT

Emergency Health Information Summary

School Year _____

To the Parent/Guardian: This form must be completed each school year.

Grade _____ Sex _____

Student Name _____
 LAST FIRST

Date of Birth ____/____/____

Address _____

I. EMERGENCY CONTACT INFORMATION

Student lives with _____

Parent/Guardian:

Name _____ Relationship _____ Home Phone _____
 Employer _____ Work Phone _____
 Cell Phone _____ Email _____

Parent/Guardian:

Name _____ Relationship _____ Home Phone _____
 Employer _____ Work Phone _____
 Cell Phone _____ Email _____

In case of an emergency and a parent/guardian is not available, contact/release my child to:

1. Name _____ Relationship _____
 Home Phone _____ Cell Phone _____ Work Phone _____
- 2.. Name _____ Relationship _____
 Home Phone _____ Cell Phone _____ Work Phone _____

Special notes regarding contact/release information: _____

II. ANNUAL HEALTH UPDATE: Primary Health

Preferred

Care Provider: _____ Hospital: _____

Yes	No	Check "Yes" or "No"
		Has your child been diagnosed with a life threatening allergic condition ? Specify: _____ Please indicate any symptoms that your child experiences which would indicate a severe allergy. (Local swelling does <i>not</i> indicate a severe allergic reaction.) Itching or swelling of eyes lips tongue/mouth Hives "Thready pulse", "passing out"/loss of consciousness Itching or tightness in the throat, hoarseness Shortness of breath, coughing or wheezing Does your child have an Epi-Pen or other medicine for a severe life-threatening allergy Yes No. If "Yes", it is strongly advised that he/she have this medication in school; it is required for interscholastic sports, grades 7-12, along with a physician's order specifying that he/she is able to "self-administer" it. Carefully read the School Medication Policy below.
Yes	No	Does your child have any of the following?
		Asthma or RAD (Reactive Airway Disease). If your child uses an inhaler, it may be advisable that he/she have their inhaler in school. It is required for interscholastic sports, grades 7-12, along with a physician's order specifying that he/she is able to "self-administer" it. Carefully read the School Medication Policy below.
		Diabetes
		Heart Problem. Specify:
		Seizure Disorder. Specify type: _____ Date of last seizure: _____
		Other medical conditions. Specify:
		Other mental health conditions. Specify:
List medication (s) that your child is currently taking:		
List allergy (s) to medication:		
SCHOOL MEDICATION POLICY: If your child has a condition that requires medication in school, a written physician's order is required. No medication may be carried in school by a student; this applies to medications "over the counter" as well. There are several exceptions for students needing emergency medications whose order specifies that they may self-carry and self-administer their medication. All medication must be delivered to the school Health Office by the parent/guardian with the physician's order and written parental permission. Medication order forms are available through the Health Office and online.		
PHYSICAL EXAMINATION REQUIREMENT: NYSED requires an annual physical examination for students entering Grades K, 1, 3, 5, 7, 9, and 11. If I do not turn in a physical examination form within 30 days of the start of school, I give permission for the school doctor to examine my child.		

I understand that if my child's health status changes during the school year, I will provide updated information to the Health Office. I give permission for the school district to contact my child's primary healthcare provider for the purpose of clarifying/obtaining immunization records, health appraisals, medication orders and/or pertinent medical information.

Parent/Guardian Signature: _____ Date: _____