

Emergency Information

Annual Update Required

Student _____

Concord Carlisle Health Office

Date of Birth: _____ Year of Graduation: _____

Address: _____

Lives with: _____

Health Insurance: Private Public None Dental Insurance: Yes No

Doctor: _____ Tel. #: _____ Dentist: _____ Tel. #: _____

Please provide the following information in the order which parties and numbers should be contacted first.

Parent/Guardian 1: _____ Relationship: _____

Address: _____ Email Address: _____

() Cell: _____ () Work: _____ () Home: _____

Parent/Guardian 2: _____ Relationship: _____

Address: _____ Email Address: _____

() Cell: _____ () Work: _____ () Home: _____

Please list 2 neighbors and/or relatives whom we may call, or to whom we may release your child in an emergency.

() Name: _____ Relationship: _____ Tel #: _____

() Name: _____ Relationship: _____ Tel #: _____

OPTIONAL: Student Cell Phone # _____

I authorize the school nurse or delegate to administer the following medication according to school physician medication order:Acetaminophen (Tylenol) Yes No Cough Drops Yes NoIbuprofen (Advil) Yes No Topical Antibiotic Ointment Yes No

Students are permitted to carry rescue inhalers, supplies for care of diabetes, and epinephrine for severe allergies.

All other medications needed during the school day must be brought to and administered via the Health Office.

Parent/Guardian Signature: _____ Date: _____

HEALTH HISTORY:

ALLERGIES	Reaction	Treatment
Food:		
Medication:		
Other:		

Asthma: Yes No Treatment: _____Head Injury: Yes No Date(s): _____

Health Concerns in School _____

CURRENT MEDICATION AND PURPOSE: _____**Release:** I give permission to exchange information with my child's health care provider for referral, diagnosis and treatment.

Parent/Guardian Signature _____ Date _____

In the event of an emergency, your child will be transported by ambulance to the nearest hospital.**The above information will be provided to the emergency responders.**