Catalina Foothills School District
Health Information / Emergency Contact Form

Student Name: _____

(Last Name) (First Name)

School: _____

Birth date:_____ Sex: F M Teacher:_____ **Grade:** _____

Address: _____

Mother's Name:_____
Home Phone: _____
Work Phone: _____
Cellular _____
EMAIL: _____

Father's Name:_____
Home Phone: _____
Work Phone: _____
Cellular _____
EMAIL:_____

Student lives with: Both Parents _____ Mother _____ Father _____ Other (please indicate) _____
Please explain custody arrangements if applicable _____

Persons who will pick up and care for the student if parents cannot be reached:
Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Doctor's Name:_____ Phone: _____

Does the student have any of the following:
Glasses/Contacts _____ Color Vision Deficiency _____ Hearing problems / aids _____

Assistive devices _____

In case of emergency, our procedure will be to contact the parent. If we are unable to reach the parent, the seriousness of the problem will dictate the course of action to be taken:

1. The person you designate may be asked to care for your child.
2. In accordance with district policy, the school nurse, principal, or authorized designee shall call an emergency medical service if it appears hospital treatment may be required. In the event the paramedics are called and emergency transportation is advised, the individual patient shall be responsible for the cost.

Do you give your consent for your child to be taken to the closest hospital by ambulance if necessary, and emergency care be provided in the event you cannot be reached?

Yes_____**No** _____ **Hospital Preference:** _____

Do you give your consent to share relevant health information regarding your child with appropriate school / and or emergency personnel as necessary? This would include permission for communication between the health provider and school nurse to facilitate this process.

Yes_____**No** _____

***PARENT/GUARDIAN SIGNATURE*:**_____**DATE:**_____

THIS FORM MUST BE SUBMITTED TO THE HEALTH OFFICE BEFORE STUDENT STARTS SCHOOL

Please complete other side. **1 of 2 pages**

STUDENT NAME: _____DATE OF BIRTH: _____GRADE:_____

*** <u>Circle</u> the health concerns/conditions that your child has <u>NOW</u> :** *Add any comments to the Health Problems listed.*

ADD/ADHD:	Headaches/Migraines/Past Concussions (Circle those that apply).
Allergy to foods: List:_____ _____ Does your child need medications at school to treat an allergic reaction YES_____ NO_____ ***If yes, please contact RN and return an Allergy Action Plan to the Health Office with the medications.**	Heart: High Blood Pressure: Liver: Menstrual Cramps: Mild/Severe
Allergy to Medications: List:	Recent Operations/Serious Injuries:
Allergy to insect bites_____ Pollen_____(√ all that apply)	Recurrent Ear Infections;
Anaphylaxis: (to what) _____ (***Contact RN)**	Urinary/Kidney:
Arthritis/Orthopedic:	Emotional/Psychiatric/Depression:
Asthma (***Contact RN):**	
Diabetes (***Contact RN**):	Any other significant conditions or disorders:
Seizure Disorder (***Contact RN):**	

***Forms for student to carry and self-administer Epi-Pen and Inhaler are available on the CFSD website & in the Health Office**

****Please make an appointment with the School Nurse (RN) to discuss any SIGNIFICANT health issues.**

Medications Taken at HOME	Dosage/Frequency	Reason
1.		
2.		
3.		

Parent/Guardian Permission for Over the Counter Medications:

Acetaminophen, (generic Tylenol): an aspirin-free pain reliever can be given for relief of mild headache or pain.
Ibuprofen: for mild to moderate menstrual pain or musculoskeletal pain, for **<u>Middle School and High School students only.</u>**
Tums Tablets, an antacid, can be given for the relief of heartburn, gas, or mildly upset stomach.

Please CIRCLE those medications you give permission for your child to receive through the Health Office:

YES	**NO**	**Acetaminophen (generic Tylenol)** **5 yrs of age: 240 mg** **6-11 yrs of age: 325 mg** **12 + yrs of age: 325 mg - 650mg**		**YES**	**NO**	**Ibuprofen – 200mg tablets** **<75lbs – 200 – 400mg every 6-8 hours as needed** **>75lbs – 400 mg every 6-8 hours as needed**
YES	**NO**	**Cough drops – High School only**		**YES**	**NO**	**Tums Tablet – 2 tablets by mouth**

I hereby authorize the designate of Catalina Foothills School District to be my agent, to give the age appropriate dose of the above named medications as directed to my child. **If there is a Health Assistant in your child's school, a parent will be contacted prior to administration of these medications. If the parent cannot be contacted, the medication will be given at the discretion of the district School Nurse (RN).**

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

SUBMIT TO HEALTH OFFICE BEFORE STUDENT STARTS SCHOOL. ***Please complete other side***

<u>NOTIFY HEALTH OFFICE OF ANY INFORMATION CHANGES IMMEDIATELY.</u> _____ **2 of 2 pages**