

**Catalina Foothills School District  
Health Information / Emergency Contact Form**

**Student Name:** \_\_\_\_\_ **School Year:** \_\_\_\_\_  
(Last Name) (First Name)

**School:** \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: F M Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

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

**Parent/Guardian Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cellular: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Student lives with: Parents/Guardians: \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cellular: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**\*\*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\*\*\***

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STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

\*List the health concerns/conditions that your child has **NOW**: 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 a life-threatening allergic reaction* YES _____ NO _____ Will your child sit at the nut-free table YES _____ NO _____ <b>*If yes, please contact RN and return a FARE Allergy Action Plan to the Health Office with script and medications*</b>	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):	Any other significant conditions or disorders:
Diabetes (*Contact RN):	
Seizure Disorder (*Contact RN):	

**\*\*Please make an appointment with the School Nurse (RN) to discuss any SIGNIFICANT health issues\*\***  
Forms for student to carry and self-administer emergency medications are available on the CFSD website & in the Health Office

Medications Taken at SCHOOL	Dosage/Frequency	Reason

Medications Taken at HOME	Dosage/Frequency	Reason

**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.

**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 – 400 mg every 6-8 hours as needed >75lbs: 400 mg every 6-8 hours as needed
YES	NO	Cough drops at the HS 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: \_\_\_\_\_

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\*\*\*Please complete other side\*\*\*

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NOTIFY HEALTH OFFICE OF ANY INFORMATION CHANGES IMMEDIATELY.