

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: _____

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: _____

*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: _____ _____	Heart:
Does your child need medications at school to treat an allergic reaction* YES _____ NO _____	High Blood Pressure:
Will your child sit at the nut-free table YES _____ NO _____ *If yes, please contact RN and return a FARE Allergy Action Plan to the Health Office with script and medications*	Liver:
Allergy to Medications: List:	Menstrual Cramps: Mild/Severe
Allergy to insect bites _____ Pollen _____ (✓ all that apply)	Recent Operations/Serious Injuries:
Anaphylaxis: (to what) _____ (*Contact RN)	Recurrent Ear Infections;
Arthritis/Orthopedic:	Urinary/Kidney:
Asthma (*Contact RN):	Emotional/Psychiatric/Depression:
Diabetes (*Contact RN):	Any other significant conditions or disorders:
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 – 400mg 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:** _____

SUBMIT TO HEALTH OFFICE BEFORE STUDENT STARTS SCHOOL.

Please complete other side

NOTIFY HEALTH OFFICE OF ANY INFORMATION CHANGES IMMEDIATELY. _____ 2 of 2 pages