Twin Valley Middle High School

STUDENT EMERGENCY/HEALTH INFORMATION FORM/2019-2020

A new emergency/health form must be completed each year. Please notify the school immediately if any information changes during the school year. Please print.

Date: ________

Student's Name ______________________________ DOB ______________ Grade ________

EMERGENCY CONTACT INFORMATION

Parent/Guardian #1 ______________________________ Telephone ______________________
Place of Employment ______________________________ Work hours/phone #______________________
Email ______________________________ Cell Phone ______________________

Parent/Guardian #2 ______________________________ Telephone ______________________
Place of Employment ______________________________ Work hours/phone # ______________________
Email ______________________________ Cell Phone ______________________

*Please include cell phone, pager, etc. numbers where you may be reached if not home ______________________

Please list two (2) nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached. **IMPORTANT** – in case of emergency early school closings, illness, and/or injury.

1. ____ Telephone ______________________
   Name Address
2. ____ Telephone ______________________
   Name Address

In case of accident or illness, I request the school to contact me. If not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense. I authorize the school to release a copy of this emergency health form to the emergency personnel. I also authorize the school to send and receive medical information to/from my child's health care providers.

Signature of Parent/Guardian ______________________________ Date____________

PERMISSION FOR OVER THE COUNTER MEDICATIONS TO BE GIVEN AT SCHOOL

May the school administer any of the following if necessary?
Tylenol (Acetaminophen) ___yes ___ no Benadryl (Diphenhydramine) ___ yes ___no Motrin (Ibuprofen) ___yes ___ no
Tums/Antacid ___ yes ___no Caladryl/Calamine ___ yes ___no Lip Ointment ___yes ___no Cough Drops ___yes ___no
Topical Bacitracin/Triple Antibiotic ointment ___ yes ___no ophthalmic eye wash ___ yes ___ no Sting-Stop gel yes___no__
Topical Sore Joint Rub _yes__no Aloe Vera Gel/Burn Cream ___yes ___no Generic Cramp Tab ___yes ___no
Aquafor used for minor skin irritations ___yes ___no Decongestant Tablet ____yes____no Sun Block ____yes____no

Signature of Parent/Guardian______________________________ Date ______________

Any known **ALLERGIES** (medication/food or other)? ____YES ____NO
IF YES, please list allergen(s) with reaction and preferred treatment for each (if epinephrine is necessary an **emergency action plan** MUST be completed)

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____

Please read and fill out reverse side

STUDENT'S NAME:_______________________________________ **2019-2020**

MEDICAL PROVIDERS

Child's Local **Doctor** ______________________ Telephone______________ Last seen______________

Date of last physical **(Well-Care Exam)**____

A comprehensive **Well-Care Exam** (physical) is not an appointment for sickness, injury, or chronic health need

Has your child received any immunizations in the past year? _____ YES ______ NO

If YES, please indicate Immunization(s) and date: ____

Child's Local **Dentist** ______________________ Telephone______________ Last seen______________

Child's **Orthodontist** ______________________ Telephone______________ Last seen______________

MEDICAL HISTORY

Does your child have any current health problems, illness, disability (allergies, seizures, asthma, add/adhd, diabetes, bleeding disorder, mental health conditions, nose bleeds, fainting spells, frequent stomach aches, frequents ear aches, migraines, anxiety, cardiac problems, concussions, or other) the school should be aware of? ____YES ____NO

If YES, list problem(s) and how best to manage at school: ____

____

____

Does your child wear glasses or contacts? ______ YES ______ NO Date of last eye exam/where:________________

Does your child wear hearing aids? ____YES ____NO Date of last hearing exam/where:____________________

DAILY MEDICATION LIST

(Prescription and Non-Prescription, including inhalers)

MEDICATION	DOSAGE	FREQUENCY

Will any medications be needed during the school day? ____YES ____NO

IF YES, please list ____

If your child uses an inhaler, does he/she use a spacer? ____YES ____NO

*****Please note: Inhalers and Epi-Pens need doctor signed emergency plans**(these are available on Health office website)**

[The following questions are to be used for State statistics – not student specification]

Has a doctor, nurse, or other health professional EVER said that your child has Asthma? ____ YES ____ NO ____ NOT SURE

If yes, does your child still have Asthma? ____ YES ____ NO ____ NOT SURE

Does your child have health insurance? ____YES ____ NO

If yes, please check which one ___ BC/BS, ___MVP, ___ DR. DYNASAUR/MEDICAID/OTHER ____________________

Would you like the school to send you information about health insurance? ____ YES ____ NO

Does your child have dental insurance? ____ YES ___ NO

Would you like the school to send you information about dental insurance? ____ YES ____ NO

THANK YOU for completing both sides of this form completely.