

# SVSD Health Services

## Confidential Emergency Health Information

Please complete and return to your child's school immediately. This form is to be completed ANNUALLY.

Has information changed within the past year?  Yes  No

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M  F

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

Parent/ Guardian email address: \_\_\_\_\_

[Nurses may use email to obtain updates regarding student care plan information]

*In order to provide a safe & healthy environment for your child this information will be accessible to appropriate school staff who may have contact with your child.*

### A. CURRENT HEALTH CONDITIONS (check the ones that may affect your child at school)

- |   |   |
|---|---|
| <input type="checkbox"/> Severe allergy* (requiring emergency medication) | <input type="checkbox"/> Bowel disorder                             |
| <input type="checkbox"/> Asthma*  | <input type="checkbox"/> Cardiovascular Condition                   |
| <input type="checkbox"/> Diabetes*  | <input type="checkbox"/> Orthopedic problem                         |
| <input type="checkbox"/> Seizure Disorder*                                | <input type="checkbox"/> Hearing problems                           |
| <input type="checkbox"/> Mental Health Issues                             | <input type="checkbox"/> ADD/ADHD                                   |
| <input type="checkbox"/> Neurological Disorder _____                      | <input type="checkbox"/> Skin Disorder _____                        |
|   | <input type="checkbox"/> Frequent migraines                         |
|   | <input type="checkbox"/> Vision Problems (except corrective lenses) |
|   | <input type="checkbox"/> Other _____                                |

\* Potentially life-threatening conditions REQUIRE that a care plan be in place (contact the school nurse)

Additional comments/physical limitations: \_\_\_\_\_

**B. MEDICATION:** Is medication needed at home? Yes  No

Name of medication: 1) \_\_\_\_\_ 2) \_\_\_\_\_

Is medication needed at school? Yes  (please see note below) No

Name of medication: 1) \_\_\_\_\_ 2) \_\_\_\_\_

#### PARENT, PLEASE NOTE:

Before medication can be allowed on school campus, a Physician's Orders/Parent Consent form, available in the school office and on the school district website, must be completed by the parent & physician and kept on file.

*In case of serious injury, illness or an emergency at school the District will make every attempt to reach the student's parents or the person(s) designated. In the event that the child's parent(s), guardian(s) or physician cannot be reached, the building administrator or designee will make a decision as to the most appropriate action to take in the student's best interest.*

Parent: \_\_\_\_\_ Date: \_\_\_\_\_