## Huntingdon Special School District

## School Health and Emergency Information Form

Bus #: ________________ School Year: ____________

Name: ______________________________________________________________
(Last) (First) (Middle) (Preferred/nickname)

Male OR Female (Circle One) Date of Birth: _______________________________

Age_________ Grade ___________ Homeroom Teacher_______________________
(Circle one)

**Custodial Parent/Legal Guardian with whom student has Primary Residence:**

HIS Name: _____________________ Relationship: ___________________________

Home Phone: ___________________ Cell Phone: ____________________________

Work Phone: _________________________

Address ______________________________________________________________
(Street, City, ST, Zip code)

HER Name: _____________________ Relationship: ___________________________

Home Phone: ___________________ Cell Phone: ____________________________

Work Phone: _________________________

Address ______________________________________________________________
(Street, City, ST, Zip code)

Siblings (please list): ___________________________________________________

**Alternate Adult Contacts**: in case of emergency, I hereby authorize HSSD to allow my child to leave school only with the parent or legal guardian(s) listed above or the following persons:

________________________________1. _________________ 2. __________________
Name/Relationship Contact Phone Numbers

________________________________1. _________________ 2. __________________
Name/Relationship Contact Phone Numbers

Doctor Name/Phone #: ______________________ Dentist/Phone #: ___________________

| Assessment of Student's Health<br>To the best of your knowledge, has your child had any problem with the following?<br>Please check yes or no. | | | |
|---|---|---|---|
| **Condition** | **Yes** | **No** | **Comments if "Yes"** |
| Allergies (food, insects, drugs, etc.) | | | |
| Allergies (seasonal) | | | |
| Asthma or breathing problems | | | |
| ADHS/ADD | | | |
| Behavioral Problems | | | |
| Bladder/Kidney Problems | | | |
| Bleeding/Clotting Problems | | | |
| Bowel Problem | | | |
| Cerebral Palsy | | | |
| Cholesterol | | | |
| Cystic Fibrosis | | | |
| Dental Problems | | | |
| Developmental Problems | | | |
| Diabetes | | | |
| Downs Syndrome | | | |
| Dyslexia/Learning Disorder | | | |
| Emotional problems | | | |
| Head, Spinal Injury, Concussion | | | |
| Headaches/Migraines | | | |
| Hearing Problems/Deafness | | | |
| Heart Problems/Murmur | | | |
| Hospitalizations (when, why) | | | |
| Hypertension (high blood pressure) | | | |
| Muscular/Orthopedic Problems | | | |
| Nutritional Problems | | | |
| Overweight | | | |
| Premature At Birth | | | |
| Psychological/Psychiatric (anxiety, depression) | | | |
| Seizures/Epilepsy | | | |
| Sickle Cell Disease (not trait) | | | |
| Special Diets | | | |
| Speech Problems | | | |
| Surgery | | | |
| Underweight | | | |
| Vision Problems | | | |
| Other: | | | |

List all prescription and over-the-counter medications your child takes regularly including dosage, frequency, and reason for medication:

______________________________________________________________________________

______________________________________________________________________________

Please note any other concerns of which the school needs to be aware:

______________________________________________________________________________

______________________________________________________________________________

_____Yes _____ No

**I give the school nurse permission to contact my child's physician or dentist should it become medically necessary.**

**Signature of Parent or Legal Guardian:** ______________________________**Date**____________