School Nurse Emergency Information

School Year ______________

Carver Public Schools

Teacher/Grade_____________

Student emergency contact information should be accurate and current. This form needs to be completed upon registration and at the start of each school year. Thank you for your cooperation.

Student's Name____ Sex______ Birth date ______________

Home Address____ Home phone ____________________

Mailing Address____ (if different)

Parent/Guardian_____________________________ Address _________________________ Cell phone _______________

Employer ____Work phone __________________________________

Email: ____

Parent/Guardian_____________________________ Address _________________________ Cell phone _______________

Employer ____Work phone __________________________________

Email: ____

If parent/guardian cannot be reached, I give permission for the following people to pick up my child:

Name _____________________________ Relationship_______________________ Phone ______________________

Name _____________________________ Relationship_______________________ Phone ______________________

Pediatrician ____ Phone __________________________

Dentist ____ Phone __________________________

Please list medications your child regularly takes at home or school ____

Please check all that apply to your child:

___ Severe allergy requiring EpiPen (food/insects/meds/environmental) _______________________________________ ___

Allergies - other____

___ Asthma ___ Diabetes ___ Seizures ___ Migraines ___ Heart Condition ___ ADD/ADHD

___ Vison problem ____ glasses ____contacts ____ Hearing problem ___ Right ear ___ Left ear

___ Any significant illness/injury/surgery in the past year ____ ___

Other health condition- specify (please use reverse side if needed) ____

If your child requires medication or special care at school, please contact the nurse. A signed order from a licensed prescriber and written parental permission is required for medicine or treatment given at school (except as noted below).

I give permission for the School Nurse to administer the following medication to my child per Physician Standing Orders:

Acetaminophen (Tylenol) ___ Yes ___ No **Diphenhydramine (Benadryl) ___ Yes ___ No**

Ibuprofen (Motrin/Advil) ___ Yes ___ No **Calcium Carbonate (TUMS) ___ Yes ___ No**

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school and/or emergency medical personnel when needed to meet my child's health and safety needs. Yes __ No __

I give permission to the school nurse to contact my child's doctor and share appropriate school and medical information when needed. Yes __ No __

Parent signature ____ Date __________________________