Emergency Care Form

Student Name: _____ Grade: _____

Does your child have Asthma? ☐ Yes ☐ No Asthma Medications: _____

Does your child have any allergies (food, insects, medication)? ☐ Yes ☐ No

_____

Current Medications: _____ _____

_____ _____

Taken at home Taken at school

No medications will be dispensed until this form is received in the Health Office

In addition to First Aid, the School Nurse may treat my child with:

Acetaminophen (Tylenol)	☐ Yes	☐ No	Cough Drops (Halls)	☐ Yes	☐ No
Ibuprofen (Advil/Motrin)	☐ Yes	☐ No	Anbesol/Oragel	☐ Yes	☐ No
Throat Lozenges (sore throat)	☐ Yes	☐ No	Antacids (Tums)	☐ Yes	☐ No
			Claritin 10MG	☐ Yes	☐ No

Significant Medical Conditions (if yes, please explain)

Cardiac	☐ Yes	☐ No	
Concussion	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Eating Disorder	☐ Yes	☐ No	
Gastrointestinal Disorder	☐ Yes	☐ No	
Hearing Disorder	☐ Yes	☐ No	
Menstrual Disorder (females)	☐ Yes	☐ No	
Orthopedic Condition	☐ Yes	☐ No	
Respiratory Condition	☐ Yes	☐ No	
Psychiatric Disorder	☐ Yes	☐ No	
Seizure Disorder	☐ Yes	☐ No	
Skin Disorder	☐ Yes	☐ No	
Vision Disorder	☐ Yes	☐ No	
Other (please specify)			

Does your child wear glasses or contacts? _____

Please specify any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her education:

_____

I understand that if my child needs immediate medical attention and the school is unable to reach a parent or designated emergency contact my permission is granted to take my child to the emergency room for treatment. I also understand that this information may be shared with all appropriate school personnel.

_____ _____

Parent/Guardian Signature Date