**Student Information**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_ M / F \_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_

 Last First Middle

Student Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consent to use for contact: Yes / No

Student Lives With: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent / Guardian Contact Information**

1. Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact/ ER Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best Contact / ER Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please identify which parent should be contacted** **first**: 1st \_\_\_\_\_ or 2nd \_\_\_\_\_

Does your child go to a location other than home after school: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, please list care provider and contact number:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others authorized to pick your child up from school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contacts**

List two names of persons who will assume temporary care of your child if you cannot be reached and your child needs to leave school due to an illness.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_

**Please complete other side for Medical Information**

**Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Known Allergies**: \_\_\_\_\_ Insects \_\_\_\_\_ Foods \_\_\_\_\_ Drugs \_\_\_\_\_\_ Animals \_\_\_\_\_ Other

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Does your child have an Epipen? Yes \_\_\_\_\_ No \_\_\_\_\_\_\_

*If yes, a medical order/action plan and epi pen* ***must*** *be submitted to the school nurse*.

* Does your child have asthma or use an inhaler? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

 *If Yes, A medical order/action plan and inhaler* ***must*** *be submitted to the school nurse*.

* Please list any medications taken at home or school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please note that **ALL** medications, including over the counter medications, to be given at school must be prescribed by a MD, Dentist, APRN, PA, Optometrist and Podiatrist. The order must accompany the medication in its **original** containerand be delivered by a parent/adult to the school nurse.

* Other health concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Student’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_

 Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_

 Does this student have **Health Insurance**: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

\*If medically necessary the child will be transported to Connecticut Children’s Medical Center unless otherwise noted.

In the event of anaphylaxis, a life-threatening event, the school nurse or, in the absence of the school nurse, a qualified school employee will administer Epinephrine in accordance with the medical orders set forth by the School Medical Advisor and CT PA 14-176, unless written notice by parent opting out is received.

I understand that in the event of a serious injury/illness the school will contact me. If medical transport is required, I give permission for the school to transport the student for medical care as deemed necessary.

I understand, and give permission for the school nurse to provide health services, education, health screenings mandated by the State of Connecticut, and routine first aid according to approved medical guidelines.

Parent Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Revised 3/21/16 lh