St. Luke's Lutheran School – 2014-2015 Health/Emergency Information

Teacher:			Grade/Class:	
Student's Last Name:	Student's First Name:	Student's Middle Name:	☐ Male ☐ Female	Birth date (m/d/y):
Home Address:	City:		State	Zip Code
Mother's Name:	Home Phone:		Cell Phone:	
Place of Work:	Work Phone:		E-mail:	
Father's Name:	Home Phone:		Cell Phone:	
Place of Work:	Work Phone:		E-mail:	

With whom does child live? **Eye Glasses:** ☐ yes ☐ no **Contact Lenses:** ☐ yes ☐ no

PERSONS AUTHORIZED TO CARE FOR CHILD IF PARENT CANNOT BE REACHED:

Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:
Name:	Relationship:	Phone:	Cell Phone:

Physician's Name: Phone:

Please list allergies: ☐ **Check if your child has an EPI Pen**

Please list daily medications:

Please list your child's health conditions or concerns:

St. Luke's Lutheran School Parental Consent

I understand that unless I request an exemption in writing (to the principal of the school), my child will participate in the School Health Services Program, which may include health appraisal and screening in vision, hearing, growth and development, nutrition, dental health, scoliosis, and communicable diseases as required by law. The information provided will be used in a confidential and professional manner, shared only with school personnel as needed, for the purpose of meeting my child's health and educational needs.

In the event of serious accident or illness, I request that the school contact me. If I cannot be reached, the school may make whatever arrangements are necessary to provide emergency care and treatment for my child. This may include conveyance to and treatment at a hospital or other medical facility. I will assume responsibility of payment for services rendered.

In the event of accident or illness that necessitates my child leaving school, I request that my spouse or I be contacted. If the school is unable to contact either, I request that one of the persons listed on the reverse side be contacted and requested to care for my child.

A photocopy of this document may be taken and shall be considered valid as the original. **Please check lines below.**

____ I give permission for the communication between the school nurse and my child's health care provider, regarding questions about medications or information regarding care for my child at school.

____ I give my permission to the school nurse/guidance counselor to transmit via email health information which can include health clinic visits, medication information, health care plans, and guidance records.

____ I do not give my permission for email transmission.

Signature of Parent or Guardian: **Date:**

Rev. Date 6/17/14