St. Luke's Lutheran School 2016 – 2017 Health / Emergency Information

TEACHER ___________________________________ **GRADE** ____________

STUDENT ____ BIRTHDATE ________________ M __ F __
LAST FIRST MM/DD/YY

HOME ADDRESS ____
NUMBER and STREET CITY STATE ZIP CODE

MOTHER'S NAME ________________________________ FATHER'S NAME ______________________________

CELL PHONE ___________________________________ CELL PHONE ________________________________

HOME PHONE __________________________________ HOME PHONE ______________________________

WORK PHONE __________________________________ WORK PHONE ______________________________

E - MAIL _______________________________________ E –MAIL ____________________________________

List two local persons authorized to care for child if parents cannot be reached (additional room on back)

NAME ______________________________ CELL # _____________________ HOME # _____________________

NAME ______________________________ CELL # _____________________ HOME # _____________________

MEDICAL INFORMATION

ALLERGIES ____ Epi Pen Prescribed __ Yes __ No

MEDICATIONS ____

HEALTH HISTORY OR CONCERNS ____

____

PHYSICIAN'S NAME ____ **PHONE** __________________________

PARENTAL CONSENT

____ (Initial consent) I/We 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.
____ (Initial consent) I/We give permission to the school nurse to transmit via email health information which can include health clinic visits, medication information, and health care plans.

I/We understand, in the event of accident or illness, the school nurse or her designee will assess the medical issues presented and determine appropriate treatment and actions.

- If the accident or illness necessitates my child leaving school, a parent/legal guardian will be contacted using the information provided above. If the school is unable to contact a parent/legal guardian, one of the persons listed on this form will be contacted and requested to care for my child.
- In the event of a serious accident or illness, the school will call 911. A parent/legal guardian will also be called using the information provided above. If the school is unable to contact a parent/legal guardian, the school may make necessary arrangements to provide emergency care and treatment for my child. This may include conveyance to and treatment at a hospital or medical facility. I understand that I assume responsibility of payment for services rendered. A photocopy of this form may be taken and shall be considered valid as original.

I understand that my child will participate in the School Health Services Program. This program may include health appraisals and screenings in vision, hearing, growth and development, nutrition, dental health, scoliosis and communicable diseases as required by law. I also consent to the sharing of my child's health information listed above with appropriate school personnel unless specified in writing to the principal.

Parent Signature ____ **Date** ____________________

St. Luke's Lutheran School 2016 – 2017 Authorization to Pick up Child

TEACHER ___________________________________ **GRADE** ___________

STUDENT ____

LAST FIRST

Students may be released to the people listed below.

NAME ______________________________ CELL # _____________________ HOME # _____________________

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