

Emergency Health Form – Lakewood School Twin Lakes District #4

Student Information: please write above the line

Student Last Name	First Name	Middle Name	Birthdate	Grade	Male/Female	Social Security Number
				() -		
Student address (Check if new) <input type="checkbox"/>	City	State	Zip Code	Home Phone (Check if unlisted) <input type="checkbox"/>	Insurance Co.	Policy #
				() -		
Family Doctor	Doctor Phone #		Family Dentist		Dentist Phone #	

CONFIDENTIAL HEALTH INFORMATION: If your child's doctor has told you your child has any of the problems below, please "X" all that apply and answer questions related to the problem

MY CHILD HAS NO KNOWN HEALTH PROBLEMS **MY CHILD'S HEALTH CONDITION IS POTENTIALLY LIFE THREATENING**

Medication (list names of all medications child takes, doses and times given) :
**IMPORTANT: Each medication given at school requires written parental consent. Each prescription medication requires a physician's written order and written parental consent. Medication forms may be obtained from the school office.*

Attention Deficit Disorder with or without hyperactivity, (list medications) : _____

Allergies, Types: Foods, list foods: _____ EPI-PEN: Yes/No (Circle) _____
 Other Latex/Rubber Medication/Allergies: (List Here) _____
 Bees/Wasps/Other Insects: List medication: _____ EPI-PEN: Yes/No (Circle) _____

Describe allergic reaction: _____

Asthma or other breathing problems, describe (list medication or treatment) : _____

Diabetes. List types of insulin, dose and times taken: _____

Emotional/Psychological problems, describe. List any medication: _____

Heart Condition, describe. List any medication: _____

Migraines: _____

Seizure Disorder, describe type. List any medication: _____

Swallowing, Stomach or Intestinal disorders: _____

Vision, Hearing or Speech problems, describe: _____ Hearing Aids Ear Tubes Glasses Contacts

Other, describe: _____

Parent/Guardian Name	Address	City	Home Phone	Child lives with Y/N	Employed By	Work Phone and shift hours
						() -
Parent/Guardian Name	Address	City	Home Phone	Child lives with Y/N	Employed By	Work Phone and shift hours
						() -

Please list additional emergency contacts below in the order you wish them to be called:

Name	Address	Home Phone	Work Phone and Extension	Relationship to Student
				() -
Name	Address	Home Phone	Work Phone and Extension	Relationship to Student
				() -

In case my child becomes ill or is injured anytime while at school and needs emergency medical care, and I cannot be reached, please take him/her to _____ or the nearest hospital for treatment. I agree to assume responsibility and expenses, including transportation charges incurred. **I also understand that in order to accommodate the health needs of my child, this information, and other health conditions that may arise, will be shared as needed with all Lakewood School staff with whom my child will have contact.**

SIGNATURE of Parent/Legal Guardian: _____ **Date:** _____