FRANCIS HOWELL SCHOOL DISTRICT
STUDENT HEALTH/EMERGENCY INFORMATION

Revised 03/14

STUDENT'S LEGAL NAME

M F

Last Name First Name Middle Name Gender

Student ID#: ____________________ Teacher/Grade: ________________________ Date of Birth: ________________________
Address: ________________________________ City: ___________________ Zip:_________ Home Phone:______________________

Student Resides With: ____

Father, Step-Father, Guardian, Other. Name:____Work Phone:____________________
Living in Home? ☐ Yes ☐ No Has permission to pick up from school? ☐ Yes ☐ No Cell Phone:____________________

Mother, Step-Mother, Guardian, Other. Name:_______________________________________Work Phone:____________________
Living in Home? ☐ Yes ☐ No Has permission to pick up from school? ☐ Yes ☐ No Cell phone:____________________

Physician's Name:_______________________________________ Phone: _____________________________________
Hospital Preference:____

In the event of an EMERGENCY or ILLNESS and parent/guardian cannot be reached, please provide the contact information for two people who will assume responsibility for your child. In case of a critical emergency, the Administrator or his/her designee will call 911 or appropriate emergency service and the parent/guardian. If the parent/guardian cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parents.

Name:_______________________________________Relationship:_____________________Day Phone:______________________

Name:_______________________________________Relationship:_____________________Day Phone:______________________

DOES YOUR CHILD HAVE:	NO	YES	SPECIFY	IS YOUR CHILD DIAGNOSED WITH:	NO	YES	SPECIFY
Seasonal Allergies	☐	☐		ADD	☐	☐	
Food Allergies	☐	☐		ADHD	☐	☐	
Drug Allergies	☐	☐		Anxiety	☐	☐	
Allergy requiring epi-pen	☐	☐		Autism	☐	☐	
Asthma	☐	☐		Bipolar	☐	☐	
Epilepsy/Seizures	☐	☐		Depression	☐	☐	
Diabetes	☐	☐		Emotional Condition	☐	☐	
Takes Insulin	☐	☐					
Heart Condition	☐	☐					
Kidney Disease	☐	☐					
Chronic Orthopedic Condition	☐	☐		Is your child currently under the care of a mental health provider?	☐	☐	
Skin Condition	☐	☐		If so, who?			

Has your child had a serious illness/hospitalization? ☐ NO ☐ YES
Specify:

Does your child wear glasses or contacts? ☐ NO ☐ YES Specify:

Does your child wear a hearing aid or cochlear implant? ☐ NO ☐ YES Specify:

Does your child need restrictive PE? ☐ NO ☐ YES (requires physician's written documentation)

Does your child take daily medication? ☐ NO ☐ YES Specify:____
Will your child require medicine at school? ☐ NO ☐ YES Specify:____

PRESCRIPTION AND OVER THE COUNTER MEDICATION to be given at school requires a written doctor's order and written parent permission along with the ORIGINAL bottle of medicine.

I GIVE PERMISSION for the nurse to administer acetaminophen /Tylenol® or Ibuprofen to my child in the dosage prescribed by the Francis Howell School District physician and per package directions on an "as needed" basis per school year.

ELEMENTARY LEVEL - 4 doses : ☐ NO ☐ YES **SECONDARY LEVEL** – 8 doses: ☐ NO ☐ YES

Guardian Signature__________________________________ Relationship:______________________Date:__________________