2017-2018 **[EMERGENCY CONTACT AND HEALTH INFORMATION]**

This form must be UPDATED each year. **In the case of an emergency, The Timothy School will contact 911(unless otherwise instructed by parent/guardian in writing). You will be contacted immediately. A staff member will remain with your child at the hospital until you (or someone you designate) arrive.**

STUDENT'S NAME: _____ **DOB**: _____ ALLERGIES: _____

Student lives with: Both Parents☐ Mother☐ Father☐ other☐ _____

PARENT(S)/GUARDIAN(S) CONTACT INFORMATION

Circle which parent/guardian should be contacted first

▪ **MOTHER/GUARDIAN NAME:** _____

Address: _____

_____

Phone (H):_____ (W):_____ (C):_____

Which number should we call first? _____

May we leave a message? ____

Email: _____

▪ **FATHER/GUARDIAN'S NAME:**_____

Address (If different):_____

_____

Phone: (H):_____ (W) :_____(C):_____

Which Number should we call first? _____

May we leave a message? _____

E-mail:_____

ALTERNATIVE EMERGENCY CONTACT NUMBERS

In the event of an emergency, please contact the following individuals if I/we cannot be reached. These people have permission to pick your child up from school.

Contact #1 Name: _____

Relationship to child: _____

Day phone Number: (H) _____ (w):_____

(C):_____

Contact #2 Name: _____

Relationship to child:_____

Day phone number: (H) _____ (W) _____

(C):_____

PHYSICIAN/HEALTH INSURANCE INFORMATION:

Primary Care Physician (PCP) _____ Phone Number_____

Health Insurance Company: _____ Policy/Group Number: _____

HEALTH INFORMATION

1. Does your child have **ALLERGIES** (seasonal, drug(s), bee sting/insect bite, food, latex or any other substance)? **YES☐ NO☐**
(If yes, complete **ANAPHYLAXIS EMERGENCY CARE PLAN**) **Allergens**_____ Reaction: _____

2. Is allergy life- threatening? **YES☐ NO☐**

3. Does your child have an **EPIPEN?** **YES☐ NO☐**
(If yes, complete **MEDICATION ADMINISTRATION AT SCHOOL** and send **2 EPIPENS** into school on the first day).

4. Does your child have **ASTHMA?** **YES☐ NO☐**

5. Does your child use an **INHALER** at home? **YES☐ NO☐** at school? **YES☐ NO☐**
(If yes, complete form: **MEDICATION ADMINISTRATION AT SCHOOL** and send in child's **INHALER** to school)

6. Does your child have **SEIZURES?** **YES☐** **NO☐** *Date of last seizure*: _____
(If yes, complete **SEIZURE EMERGENCY CARE PLAN**)

7. Does your child have **DIASTAT?** **YES☐** **NO☐** **CLONAZEPAM?** **YES☐** **NO☐**
(If yes, complete form: **MEDICATION ADMINISTRATION AT SCHOOL** and send **DIASTAT/ CLONAZEPAM** to school on the first day).

8. Does your child have a **VAGUS NERVE STIMULATOR (VNS)?** **YES☐** **NO☐**
(If yes, complete **VNS CARE PLAN)**

9. Does your child suffer from any other condition(s) that we should know about requiring special attention such a**s** Diabetes, GI, Eczema, Cardiac Conditions…? **YES☐** **NO☐**
(If yes, explain) _____

10. Has your child been under the care of a physician(s) or hospitalized in the past year? **YES☐** **NO☐**
(If yes, Date of last Hospitalization: _____explain)_____

11. Does he/she have any vision, hearing, communication and/or mobility issues? **YES☐** **NO☐**
(If yes, explain)_____

MEDICATIONS

Please list all current medications taken (at home and school) and keep us up-to-date on any medication changes (times, doses, new and discontinued) .

Medication	Dose:	Time:	Purpose of medication:	Potential side effects:

12. **Is your child going to be taking medication(s) at school?** **YES☐** **NO☐**
If yes, read TIMOTHY SCHOOL MEDICATION PROCEDURES and complete the MEDICATION ADMINISTRATION AT SCHOOL form. This requires both the prescribing physician and parent/guardian's signature and must be received before any medication can be given at school.

13. The school nurse may administer the following (please check)
(If yes to any of the below, please provide the school nurse with the medication(s) in the original bottle with your child's name written clearly on the label).

Acetaminophen -generic Tylenol **YES☐** **NO☐**

Ibuprofen -generic Advil **YES☐** **NO☐**

Benadryl for allergic reactions only **YES☐** **NO☐**

PARENTAL CONSENT

14. I/we give my/our consent to (1) administer above medications where indicated; (2) to share pertinent health information with my child's administrators/teacher(s); (3) contact student's health care provider to clarify facts surrounding a student's condition, medication and/or treatment plan and (4) activate 911 in the event of an emergency unless instructed otherwise in writing by parents.

X **PARENT/GUARDIAN SIGNATURE**: _____ Date: _____

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Guidance from the Family Compliance Office of the U.S. Department of Education, which has responsibility for enforcing the requirements of FERPA, instructs schools to limit access to health records and information contained in health records to those who need to know to benefit the student.