WEST ESSEX REGIONAL SCHOOLS

MEDICAL INFORMATION AND EMERGENCY FORM

(CONFIDENTIAL: ON FILE IN NURSE'S OFFICE)

PLEASE COMPLETE THE FOLLOWING INFORMATION:
Part 1.

____ _______________
STUDENT'S LAST NAME FIRST NAME MIDDLE SCHOOL YEAR

____ ________ ________
NUMBER & STREET ADDRESS TOWN GRADE SEX

________ ______________________________
AGE DATE OF BIRTH

A. PLEASE LIST THE NAMES AND PHONE NUMBERS OF PARENT/GUARDIAN. I INDICATE WITH AN "X" WITH WHOM STUDENT RESIDES.

	NAME	HOME PHONE	BUSINESS PHONE	CELL PHONE	RESIDES WITH
MOTHER					
FATHER					
GUARDIAN					

B. IN CASE OF ACCIDENT / ILLNESS, I REQUEST THE SCHOOL TO CONTACT ME. IF THE SCHOOL IS UNABLE TO REACH ME, THE FOLLOWING PERSONS HAVE *AGREED* TO ARRANGE FOR MY CHILD'S TRANSPORTATION AND CARE:

NAME	RELATIONSHIP	HOME PHONE	BUSINESS PHONE

C. IN CASE OF AN EMERGENCY, I HEREBY AUTHORIZE THE SCHOOL TO CALL THE PHYSICIAN OR DENTIST INDICATED BELOW TO FOLLOW HIS/HER INSTRUCTIONS:

PHYSICIAN______________________________ OFFICE PHONE NUMBER______________________

DENTIST______________________________ OFFICE PHONE NUMBER______________________

HOSPITAL______________________________ PHONE NUMBER______________________

PART 2.
PLEASE COMPLETE THE FOLLOWING:
DOES YOUR CHILD HAVE A HISTORY OF….

		YES	NO
1.	FAINTING WITH EXERCISE?	______	______
2.	ANY PREVIOUS JOINT DISEASE? INJURIES? FRACTURES?	______	______
3.	DIABETES?	______	______
4.	ALLERGIES TO: FOOD, MEDICINE, POLLEN, BEE OR INSECT STING?	______	______
5.	PLEASE CHECK: ASTHMA? _____ EXERCISED INDUCED ASTHMA? ___	______	______
6.	SURGERY?	______	______
7.	HOSPITALIZATION?	______	______
8.	DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S HEALTH THAT COULD HAVE IMPACT ON THEIR ROLE AS A STUDENT?	______	______

IF YOU HAVE CHECKED *"YES"* TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN:

____
____
____

DOES YOUR CHILD TAKE ANY MEDICATION AT HOME? IF YES, PLEASE COMPLETE BELOW:

MEDICATION______________________DOSAGE______________TIME ADMINISTERED____________________

PRESCRIBING PHYSICIAN__________________________PURPOSE OF MEDICATION________________________

PLEASE NOTE: ***IF THE ABOVE MEDICATION(S) NEED TO BE GIVEN DURING SCHOOL HOURS, THE DISTRICT MEDICATION FORM MUST BE COMPLETED BY PHYSICIAN AND PARENT IN ORDER FOR THE DISTRICT SCHOOL NURSES TO ADMINISTER THE PRESCRIBED MEDICATION(S) TO YOUR CHILD.***

"I GIVE MY PERMISSION FOR THE SCHOOL NURSE TO SHARE ALL HEALTH INFORMATION WITH THE FACULTY AS NEEDED"

______________ ____
DATE **SIGNATURE OF PARENT/GUARDIAN**