Catalina Foothills School District
Health Information / Emergency Contact Form

Student Name: _____ **School Year:** _____

(Last Name) (First Name)

School: _____

Birthdate: _____ Sex: F M Teacher: _____ Grade: _____

Address: _____

Parent/Guardian Name:_____
Home Phone: _____
Work Phone: _____
Cellular: _____
EMAIL: _____

Parent/Guardian Name:_____
Home Phone: _____
Work Phone: _____
Cellular: _____
EMAIL: _____

Student lives with: Parents/Guardians: _____ _____
_____

******Please explain custody arrangements if applicable****** _____

Persons who will pick up and care for the student if parents cannot be reached:

Name: _____ Phone:_____ Relationship: _____

Name: _____ Phone:_____ Relationship: _____

Doctor's Name: _____ Phone: _____

Does the student have any of the following:
Glasses/Contacts _____ Color Vision Deficiency _____ Hearing problems/aids _____
Assistive devices _____

In case of emergency, our procedure will be to contact the parent. If we are unable to reach the parent, the seriousness of the problem will dictate the course of action to be taken:
1. The person you designate may be asked to care for your child.
2. In accordance with district policy, the school nurse, principal, or authorized designee shall call an emergency medical service if it appears hospital treatment may be required. In the event the paramedics are called and emergency transportation is advised, the individual patient shall be responsible for the cost.

Do you give your consent for your child to be taken to the closest hospital by ambulance if necessary, and emergency care be provided in the event you cannot be reached?

Yes _____ **No**_____ **Hospital Preference:** _____

Do you give your consent to share relevant health information regarding your child with appropriate school and/or emergency personnel as necessary? This would include permission for communication between the health provider and school nurse to facilitate this process.

Yes _____ **No**_____

PARENT/GUARDIAN SIGNATURE: _____DATE:_____

THIS FORM MUST BE SUBMITTED TO THE HEALTH OFFICE BEFORE STUDENT STARTS SCHOOL

******Please complete other side******

STUDENT NAME: _____DATE OF BIRTH: _____GRADE:_____

***List the health concerns/conditions that your child has NOW:** *Add any comments to the Health Problems listed*.

ADD/ADHD:	Headaches/Migraines/Past Concussions (Circle those that apply).
Allergy to foods: List:_____ _____ Does your child need medications at school to treat a life-threatening allergic reaction* YES_____ NO_____ Will your child sit at the nut-free table YES_____ NO_____ ***If yes, please contact RN and return a FARE Allergy Action Plan to the Health Office with script and medications***	Heart: High Blood Pressure: Liver: Menstrual Cramps: Mild/Severe
Allergy to Medications: List:	Recent Operations/Serious Injuries:
Allergy to insect bites_____ Pollen_____(√ all that apply)	Recurrent Ear Infections;
Anaphylaxis: (to what) _____ (***Contact RN)**	Urinary/Kidney:
Arthritis/Orthopedic:	Emotional/Psychiatric/Depression:
Asthma (***Contact RN):**	Any other significant conditions or disorders:
Diabetes (***Contact RN**):	
Seizure Disorder (***Contact RN):**	

****Please make an appointment with the School Nurse (RN) to discuss any SIGNIFICANT health issues****
Forms for student to carry and self-administer emergency medications are available on the CFSD website & in the Health Office

Medications Taken at SCHOOL	Dosage/Frequency	Reason

Medications Taken at HOME	Dosage/Frequency	Reason

Parent/Guardian Permission for Over the Counter Medications:

Acetaminophen, (generic Tylenol): an aspirin-free pain reliever can be given for relief of mild headache or pain.
Ibuprofen: for mild to moderate menstrual pain or musculoskeletal pain.
Tums Tablets, an antacid, can be given for the relief of heartburn, gas, or mildly upset stomach.

Please CIRCLE those medications you give permission for your child to receive through the Health Office:

YES	**NO**	**Acetaminophen (generic Tylenol)** **5 yrs of age: 240 mg** **6-11 yrs of age: 325 mg** **12 + yrs of age: 325 mg - 650mg**		**YES**	**NO**	**Ibuprofen – 200mg tablets** **<75lbs: 200 – 400 mg every 6-8 hours as needed** **>75lbs: 400 mg every 6-8 hours as needed**
YES	**NO**	**Cough drops at the HS only.**		**YES**	**NO**	**Tums Tablet – 2 tablets by mouth**

I hereby authorize the designate of Catalina Foothills School District to be my agent, to give the age appropriate dose of the above-named medications as directed to my child. **If there is a Health Assistant in your child's school, a parent will be contacted prior to administration of these medications. If the parent cannot be contacted, the medication will be given at the discretion of the district School Nurse (RN).**

PARENT/GUARDIAN SIGNATURE: _____DATE:_____

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Please complete other side **2 of 2 pages**

NOTIFY HEALTH OFFICE OF ANY INFORMATION CHANGES IMMEDIATELY.