Emergency health record

Howard S. Billings High School - 2024-2025

STUDENT IDENTIFICATION

Family name: _____ First name: _____ Gender: ❑ Female ❑ Male

Address: _____ Date of birth: _____
Year Month Day

EMERGENCY PHONE NUMBERS (PLEASE PRINT)

PARENT 1:	PARENT 2:	OTHER CONTACT:
Family name:	Family name:	Family name:
First name:	First name:	First name:
Relationship:	Relationship:	Relationship:
Hone phone:	Home phone:	Home phone:
Cell phone:	Cell phone:	Cell phone:
Other phone:	Other phone:	Other phone:
Email:	Email:	Email:

To ensure your child's safety, you must inform the school of any health problems that **may require an emergency intervention at school** (severe allergy to certain foods or insect bites, diabetes, etc.).

Does your child have this type of health problem? ❑ Yes ❑ No
If yes, please fill out the reverse side of this form. ⟹

Please **notify the school of any changes** that occurs during the school year.
If your child takes any medications on a regular basis, please attach the list of medications to this record in the event we need to call an ambulance.

I authorize the school nurse and staff to read the information contained in this health record; I also authorize the nurse to examine my child, under 14 years of age, at the school's request (e.g., lice, pain, signs of infection).

_____ _____

Signature of parent, guardian or student age 14 and over. Date: Year Month Day

FAMILY NAME AND FIRST NAME OF THE STUDENT: _____

IS THERE A POSSIBILITY THAT YOUR CHILD MIGHT REQUIRE EMERGENCY MEDICAL TREATMENT, SUCH AS:

Severe allergy requiring an adrenaline injection:

Food ❑ Yes Specify: _____
Insect bite ❑ Yes Specify: _____
Other ❑ Yes Specify: _____

Medication at school: AUTO-INJECTOR: ❑ Yes which one: _____ Exp. date: _____
❑ No
Other: _____

Diabetes ❑ Yes Administration of insulin required at school: ❑ Yes ❑ No
❑ Pen ❑ Pump Specify: _____

Other medication at school: ❑ Yes which one: _____
❑ No

→ **Please provide the nurse with a medical care plan.**

Epilepsy: ❑ Yes Medication at school: Specify which one: _____

Other (e.g., asthma)

Does your **child** have another health problem that may **require an emergency intervention at school?**
❑ Yes Specify: _____
❑ No

Does your **child** need **medication** at school?
❑ Yes Which one: _____
❑ No

ANYONE WITH A SPECIFIC HEALTH CONDITION THAT REQUIRES AN EMERGENCY RESPONSE SHOULD WEAR A MEDICALERT OR SIMILAR TYPE OF BRACELET.

THE INITIAL EVALUATION MADE BY THE NURSE IS VALID FOR A DURATION OF TWO YEARS.
PLEASE INFORM THE SCHOOL AND THE NURSE FOR ANY CHANGE.

Reserved for the nurse
