



Emergency health record

Howard S. Billings High School - 2025-2026



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:
Home 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 MEDICAL ALERT 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
