



## FRANCIS HOWELL SCHOOL DISTRICT STUDENT HEALTH/EMERGENCY INFORMATION PRESCHOOL

### STUDENT'S LEGAL NAME

M    F

---

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Gender \_\_\_\_\_

Student ID#: \_\_\_\_\_ Teacher/Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Student Resides With: \_\_\_\_\_

Father, Step-Father, Guardian, Other-Name \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Living in Home?  Yes  No. Has permission to pick up from school?  Yes  No Cell Phone: \_\_\_\_\_

Mother, Step-Mother, Guardian, Other-Name \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Living in Home?  Yes  No. Has permission to pick up from school?  Yes  No Cell Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_

Please provide two people, LOCATED IN ST. CHARLES COUNTY DURING REGULAR SCHOOL HOURS, who will assume responsibility for your child in the event of an EMERGENCY or ILLNESS if either parents/guardians cannot be reached. The cost of medical attention and ambulance is the responsibility of the parents. These people will also be able to pick up your child for any reason. ANY CHANGES NEED TO BE IN WRITING.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Day Phone: \_\_\_\_\_

DOES YOUR CHILD HAVE:	HAS YOUR CHILD HAD:		
	NO	YES	SPECIFY
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Takes Insulin	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Severe Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	

Has your child had a serious illness/hospitalization?  NO  YES

Specify: \_\_\_\_\_

Does your child wear glasses?  NO  YES Specify: \_\_\_\_\_

Does your child wear a hearing aid or cochlear implant?  NO  YES Specify: \_\_\_\_\_

Does your child take daily medication?  NO  YES Specify: \_\_\_\_\_

Will your child require medicine at school?  NO  YES Specify: \_\_\_\_\_

**PRESCRIPTION AND OVER THE COUNTER MEDICATION** to be given at school requires a written doctor's order and written parent permission along with the ORIGINAL bottle of medicine.

Guardian Signature \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_