FRANCIS HOWELL SCHOOL DISTRICT
STUDENT HEALTH/EMERGENCY INFORMATION

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:	NO	YES	SPECIFY	HAS YOUR CHILD HAD:	NO	YES	SPECIFY
Allergies	☐	☐		Chicken Pox (Disease)	☐	☐	
Asthma	☐	☐		Measles (hard)	☐	☐	
Emotional Condition	☐	☐		Rubella (3 day measles)	☐	☐	
Epilepsy/Seizures	☐	☐		Mumps	☐	☐	
Diabetes	☐	☐		Ear Infections	☐	☐	
Takes Insulin	☐	☐		Bronchitis	☐	☐	
Fainting Spells	☐	☐		Hepatitis	☐	☐	
Heart Condition	☐	☐		Meningitis	☐	☐	
Kidney Disease	☐	☐		Pneumonia	☐	☐	
Orthopedic Problems	☐	☐		Tuberculosis	☐	☐	
Skin Condition	☐	☐		Whooping Cough	☐	☐	
Severe Nose Bleeds	☐	☐		Scarlet Fever	☐	☐	
ADD/ADHD	☐	☐		Other	☐	☐	

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

Does your child wear glasses or contacts? ☐ NO ☐ YES Specify:

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

Does your child need restrictive PE? ☐ NO ☐ YES (requires physician's written documentation)

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.

ELEMENTARY LEVEL: I GIVE PERMISSION for the nurse to administer acetaminophen (Tylenol®) to my child in the dosage prescribed by the Francis Howell School District physician and per package directions on an "as needed" basis 4 times per school year. **SECONDARY LEVEL**: Acetaminophen/Tylenol® or Ibuprofen 8 times per school year. ☐ NO ☐ YES

Guardian Signature_____ Relationship:_____Date:_____