Wilton Public Schools **EMERGENCY INFORMATION HEALTH OFFICE** **Wilton, Connecticut**

YEAR _____

The information on this form will be entered online

NAME OF STUDENT _____
(Last) (First) (Middle Initial)

Home Phone _____ Address _____

Birth Date _____ Parent/Guardian _____
(Mother/Guardian) (Father/Guardian)

Home or Work
~~Business~~ Phone (Father/Guardian) _____ (Mother/Guardian) _____

Cell Phone #(Mother) _____ GRADE _____ ~~TEACHER~~ _____

(Father) _____ ~~HOMEROOM~~ _____

In the event that we cannot be reached, the school staff has my permission to contact either of the people listed below for the care and transportation of my child.

_____ Cell: _____
(Name - ~~Relationship~~) (Address) Home: _____
Resident Director

_____ Cell: _____
(Name - ~~Relationship~~) (Address) Home: _____
Health Service Board Member

Physician _____ Address _____ Phone _____

Dentist _____ Address _____ Phone _____

ALLERGIES: (Please check appropriate box)

☐ Bee Stings ☐ Food ☐ Medication
☐ Nuts ☐ Other _____

MEDICATION REQUIRED: _____

CURRENT DISORDERS: (Please check appropriate box)

☐ Seizure Disorder ☐ Diabetes
☐ Asthma ☐ Other _____

MEDICATION REQUIRED: _____

CONFIDENTIAL INFORMATION FOR HEALTH OFFICE ONLY:

1. Diagnosed Medical and/or psychological health issues
2. Routine prescribed medications taken on a regular basis
3. Any other health issues

Please list: _____

This section of the form will not appear on the carbonless copy

Does your child have health insurance? ☐ **Yes** ☐ **No** ***IF NO - call 1-877-CT-HUSKY (Forms are available on District website)***

I GIVE PERMISSION TO THE SCHOOL NURSE TO GIVE NON-ASPIRIN (acetaminophen) ACCORDING TO LABEL DIRECTIONS TO MY CHILD FOR HEADACHE PAIN, MENSTRUAL CRAMPS OR ORTHODONTIC PAIN, IF, IN HER PROFESSIONAL JUDGEMENT, IT IS NEEDED.

Date: _____ Signature of Parent/Guardian _____

I HEREBY GIVE MY PERMISSION TO THE OFFICIALS OF MY CHILD'S SCHOOL TO TAKE MY CHILD TO THE PHYSICIAN, DENTIST, OR TO A HOSPITAL IF AN ACCIDENT OR SERIOUS ILLNESS OCCURS IN SCHOOL AND I CANNOT BE LOCATED.

Date: _____ Signature of Parent/Guardian _____

PLEASE RETURN TO SCHOOL HEALTH OFFICE AT START OF SCHOOL YEAR