

NAME OF STUDENT _____

(Last)

(First)

(Middle Initial)

Home Phone _____ Address _____

Birth Date _____ Parent/Guardian _____

(Mother/Guardian)

(Father/Guardian)

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.

(Name - Relationship) (Address) Cell: _____
Home: _____

(Name - Relationship) (Address) Cell: _____
Home: _____

Physician _____ Address _____ Phone _____

Dentist _____ Address _____ Phone _____

ALLERGIES: (Please check appropriate box)

- Bee Stings Food Medication
 Nuts Other _____

CURRENT DISORDERS: (Please check appropriate box)

- Seizure Disorder Diabetes
 Asthma Other _____

MEDICATION

REQUIRED: _____

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