Pearl City School District

Health & Emergency Contacts Information

Date:_____

Please complete the Health History form and return it to the main office.

Required forms:

*Complete Physical - Students entering in Kindergarten, 6th and 9th grade
*Dental Exams - Kindergarten, 2nd and 6th grades
*Eye Exams - Kindergarten and new students transferring from out of state

If there are any changes in telephone numbers or emergency contacts please notify the main office.

Emergency Contacts For : _____

(Parents/Guardian will be contacted first) (**Name of Child/Children)**

1st Contact: _____ Relationship to Child:_____

1st Phone: _____ 2nd Phone:_____ 3rd Phone:_____

2nd Contact: _____ Relationship to Child:_____

1st Phone: _____ 2nd Phone:_____ 3rd Phone:_____

Family Physician: _____ Phone: _____
Family Dentist: _____ Phone: _____
Hospital: _____ Phone: _____

Health History Informed Consent

The disclosure of student health information with the school is limited to the information necessary to serve the student's health and educational interest. Giving permission for the nurse to inform school staff of precautions and procedures is to protect your child in the classroom and to foster academic success.

_____Yes, I give informed consent to share health history information with school staff.
_____No, I do not want health information shared with any school staff.

If your child/children have any of the following, please put name(s) next to condition and if any medication is needed at school.

***ADD/ADHD**? _____ **HEART CONDITIONS**? _____

***SEIZURES**?_____ **HEADACHES / MIGRAINES**?_____

***ASTHMA**?_____ **HOSPITALIZATIONS**? _____

***ALLERGIES** (food, insect bites, medication)? _____

(*Please contact school nurse for care plan)

***DIABETES**?_____

If any other health condition exist, please explain instruction and list any medications taken at home and/or at school.

_____

In a case where my child becomes ill or is injured at school and needs emergency medical care and I cannot be reached, Pearl City School District staff is authorized to take my child to **Freeport Memorial Hospital**. I agree to assume all responsibility and expenses incurred by handling of this emergency care.

_____

Parent/ Guardian Signature Date