

# SUSD STUDENT'S HEALTH HISTORY ~ MEDICAL EMERGENCY

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ ID # \_\_\_\_\_ Student Teacher/Grade \_\_\_\_\_

**EMERGENCY CARDS ARE NOT RETAINED FROM ONE SCHOOL YEAR TO THE NEXT. The following information must be completed EVERY SCHOOL YEAR to update your student's health records.**

Birthdate of Student \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (please circle): Male / Female Student lives with (please circle): mother/ father/ guardian

Mother/Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email \_\_\_\_\_

## STUDENT'S DOCTOR INFORMATION:

Primary Care Physician Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Please check  YES if your child has any of the following health condition(s) per a physician's diagnosis. EXPLAIN UNDER **\*\*ADDITIONAL HEALTH INFORMATION\*\*** SECTION.

- |                                                                          |                                                                                    |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <input type="checkbox"/> ADD/ADHD                                        | <input type="checkbox"/> Diabetes – Type 1                                         |
| <input type="checkbox"/> Allergies                                       | <input type="checkbox"/> Diabetes – Type 2                                         |
| <input type="checkbox"/> Food                                            | <input type="checkbox"/> Eating/Weight Disorder                                    |
| List: _____                                                              | <input type="checkbox"/> Emotional/Psychiatric Disorder (e.g. depression, bipolar) |
| <input type="checkbox"/> Insect stings/bites                             | <input type="checkbox"/> Type: _____                                               |
| <input type="checkbox"/> Latex                                           | <input type="checkbox"/> Endocrine Disorder                                        |
| <input type="checkbox"/> Medication(s)                                   | <input type="checkbox"/> Gastrointestinal Disorder                                 |
| List: _____                                                              | <input type="checkbox"/> Genitourinary Disorder                                    |
| <input type="checkbox"/> Animals                                         | <input type="checkbox"/> Hearing/Ear Disorder                                      |
| <input type="checkbox"/> Seasonal                                        | <input type="checkbox"/> Hearing Aids                                              |
| <input type="checkbox"/> Life Threatening                                | <input type="checkbox"/> Heart Condition                                           |
| List: _____                                                              | <input type="checkbox"/> Hemophilia/Factor 8                                       |
| <input type="checkbox"/> Arthritis/Rheumatic Disease                     | <input type="checkbox"/> Hypertension                                              |
| <input type="checkbox"/> Asthma                                          | <input type="checkbox"/> Neuro Disorder (includes migraines)                       |
| <input type="checkbox"/> Autism                                          | <input type="checkbox"/> Orthopedic Disorder                                       |
| <input type="checkbox"/> Birth Defect / Developmental Disorder           | <input type="checkbox"/> Seizure Disorder                                          |
| <input type="checkbox"/> Cancer                                          | <input type="checkbox"/> Substance Use/Abuse                                       |
| <input type="checkbox"/> Chickenpox/Varicella (if so, give month & year) | <input type="checkbox"/> Vision/Eye Disorder                                       |
| <input type="checkbox"/> Connective Tissue Disorder                      | <input type="checkbox"/> Glasses/contacts                                          |
| <input type="checkbox"/> Cystic Fibrosis                                 | <input type="checkbox"/> Other: _____                                              |

Medication(s) and dose(s) taken at home:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

If your child needs to take prescription medication at school, you must provide the medication in the original prescription bottle with the child's name on it. If your child needs to take any over-the-counter medication, you must provide the specific, age-appropriate medication in the original, sealed container. All medication (prescription and over-the-counter) must be brought to the health office by a parent or guardian and a Medication Administration Record completed.

Medication(s) and dose(s) to be taken at school:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

### FOR SCHOOL NURSE

Circle Action Plan received from parent/guardian:

*Allergy Asthma Diabetes Seizure Other*

Nurses Note:

**\*\*ADDITIONAL HEALTH INFORMATION\*\*** Any other information which will help us understand your child physically and/or emotionally:

\_\_\_\_\_

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ ID # \_\_\_\_\_ Student Teacher/Grade \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE ON THIS ACKNOWLEDGES THE FOLLOWING:

**Permission shall be deemed granted if there is no response to the following statements.**

1. The SUSD Student Code-of-Conduct is available to parents and students on both district ([www.susd.org](http://www.susd.org)) and school web sites. A hard copy of the Code-of-Conduct is available upon request from the school.
2. It is the responsibility of the parent/guardian to update information on this emergency card with appropriate documentation as changes occur.
3. In the event of an accident or illness when authorization for medical treatment cannot be obtained from the parent or personal physician, the undersigned gives permission and assumes full responsibility for the school nurse and/or the school administrator to call for emergency medical assistance, including ambulance services. I acknowledge that I am financially responsible for ambulance and other health care expenses which may occur as a result of illness or injury of my child.
4. To assure the safety and well-being of my child, the school nurse has permission to share pertinent health concerns with appropriate school personnel.
5. Registration and enrollment for the current school year is incomplete until this emergency card has been completed and signed by the parent/guardian and returned to the school.

### SUSD CODE OF CONDUCT:

I hereby acknowledge that I have read the SUSD Code of Conduct and agree to abide by the rules and expectations contained therein.

PARENT/GUARDIAN SIGNATURE (IN INK) \_\_\_\_\_ DATE \_\_\_\_\_

**PARENT COMMUNICATION SURVEY: (We are required to collect information regarding whether or not you need interpretation and/or translation services. Please complete the following survey for each parent/guardian regardless if you need interpretation or translation services (e.g. if you speak English, please fill in English)).**

**1. Parent/Guardian Name** \_\_\_\_\_ **Native Language** \_\_\_\_\_

1. I need oral interpretation services during conferences, meetings, etc. \_\_\_Yes \_\_\_No
2. I may need written translation of school and district documents. \_\_\_Yes \_\_\_No

**2. Parent/Guardian Name** \_\_\_\_\_ **Native Language** \_\_\_\_\_

1. I need oral interpretation services during conferences, meetings, etc. \_\_\_Yes \_\_\_No
2. I may need written translation of school and district documents. \_\_\_Yes \_\_\_No

**Please note: If the second parent/guardian does not apply, please check not applicable.**  Not Applicable

PARENT/GUARDIAN SIGNATURE (IN INK) \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE (IN INK) \_\_\_\_\_ DATE \_\_\_\_\_