Cape Cod Tech

Student Health & Emergency Information Form

Student's Name: ______________________ DOB: __________ Grade: ________

Name of Parent Guardian With Whom Parent Resides: ______________________

Resident's Address: ______________________

Street Town State Zip Code

Mailing Address: (If different from above) ______________________

#1 Parent/Guardian: ______________________ Relationship: __________

Telephone numbers: Home: __________ Work: __________ Cell: __________

#2 Parent/Guardian: ______________________ Relationship: __________

Telephone numbers: Home: __________ Work: __________ Cell: __________

Alternate Emergency Contact

#1 Name: ______________________ Relationship: __________

Home: __________ Work: __________ Cell: __________

#2 Name: ______________________ Relationship: __________

Home: __________ Work: __________ Cell: __________

#3 Name: ______________________ Relationship: __________

Home: __________ Work: __________ Cell: __________

Does your child have health insurance? ______________________

Health Insurance Company: ______________________ Policy Number: __________

Physician Name: ______________________ Dentist Name: __________

Please list all the medication that your child takes: ______________________

Has your child been diagnosed with any of the following:

☐ Heart Condition ☐ Diabetes ☐ Asthma ☐ Seizure Disorder ☐ ADD / ADHD

☐ Migraines ☐ Depression ☐ Other: (Specify) ______________________

☐ Allergies (food, insect, medication, enviroment) Specify: ______________________

☐ Hearing Problems ☐ Left Ear ☐ Right Ear ☐ Hearing Aids

☐ Vision Problems (Specify) ☐ Wears Glasses ☐ Wears contact lenses

Do you give the nurse permission to administer Tylenol? ☐ Yes ☐ No Ibuprofen? ☐ Yes ☐ No

Tums? ☐ Yes ☐ No Cough drops? ☐ Yes ☐ No

Does your child require an Epipen ☐ Yes ☐ No

Does your child require an inhaler? ☐ Yes ☐ No

In the event of a medical emergency, I give permission for school officials to transport my child to the hospital if non of the personal emergency contacts provided can be reachered. ☐ Yes ☐ No

I give permission to the school nurse to share information relevant to my child's health condition with school personnel when necessary to meet my child's health and safety needs. ☐ Yes ☐ No

Signature: ______________________ Date: __________