Emergency Contact Information

Student **Grade**

Parent/Guardian **Relationship** **Cell Phone** **Other**

Street Address **City** **Zip Code**

Emergency Contact

Name Relationship Cell Phone Other Phone

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Medication/Medical Procedures : (APSD policy on medications) Any prescription medication or medical procedure(blood sugar check, tube feeding, etc.) to be administered at school or school related activities must be accompanied by written orders from a health care practitioner. NO over-the-counter medications may be administered by the school RN. All information below is confidential for the school nurse and may be shared on a need to know basis for student safety.
Screenings: APSD school nurses conduct vision/hearing/scoliosis screenings and other training based on the LDOE recommendations. Contact your school nurse if you do not want your child to participate.

Please address each yes/no question

Health History:

ADD/ADHD	☐ **YES** ☐ **NO**	☐Takes Medication at Home ☐Needs Medication at School:_____ ADD/ADHD Doctors Name:_____
Allergy	☐ **YES** ☐ **NO**	☐Environmental/Seasonal ☐Needs Medication at School:_____ ☐**Severe(Life Threatening) To:**_____ ☐Has epi-pen or other form ☐Does not have epinephrine for school Last Date Epi-Pen used ___/___/___ Allergy Doctor's Name _____
Asthma	☐ **YES** ☐ **NO**	☐Has rescue inhaler for at school Asthma Doctor's Name:_____
Cardiac (Heart)	☐ **YES** ☐ **NO**	☐Takes medicine at home ☐Needs medicine at School:_____ Heart Doctor's Name:_____
Diabetes	☐ **YES** ☐ **NO**	**SEE SCHOOL NURSE FOR DMMP**
Epilepsy (Seizures)	☐ **YES** ☐ **NO**	☐Takes Medication at Home ☐Needs Medication at School:_____ ☐Has Diastat Last date used___/___/___ Seizure Doctor's Name:_____
Sickle Cell Anemia	☐ **YES** ☐ **NO**	☐Trait ☐Disease ☐Takes medicine at home ☐Needs medicine at School:_____ ☐Last Hospitalization ___/___/___ Doctor's Name:_____
Mental Health Consideration	☐ **YES** ☐ **NO**	Type:_____ ☐Takes medicine at home ☐Needs medicine at School:_____
Other		Describe