Sugar Maple Nature School **2023-2024**

Emergency Illness-Health History Form

(To be completed by Parent/Guardian)

The information provided is confidential. This information is necessary for the health and safety of the student to assist in promoting optimal health care to facilitate the academic success of each student. Thank you for your time.

Emergency Illness-Health History Form

Student Name: _____ Birth Date:_____ Grade:_____
Last First M.I.

Address:_____
Street City State Zip

Child resides with: **o**Both Parents **o**Mother **o**Father **o**Stepfather **o**Stepmother **o**Other:_____

Parent/Guardian Name:_____Relationship:_____

Cell: (_____)_____ Employer:_____Work: (_____)_____

Parent/Guardian Name:_____Relationship:_____

Cell: (_____)_____ Employer:_____Work: (_____)_____

** ***Non-emergency/informative messages*** (such as an injury in which the student was treated and returned to class will be shared through a private message in Class Dojo.)

Emergency Contact 1 Name:_____

Relationship:_____ Phone: (_____)_____

Emergency Contact 2 Name:_____

Relationship:_____ Phone: (_____)_____

AUTHORIZATION for EMERGENCY REFERRAL and MEDICAL TREATMENT

As guardians of _____, I/we authorize school personnel to refer our child to our family doctor in the event we cannot be readily contacted and authorize the doctor to treat our child. If either our doctor or we cannot be reached and/or the situation is recognized by the attending adult as an emergency, we give the school permission to arrange transportation for our child to a medical doctor and/or medical facility. We agree to assume all costs involved, including possible ambulance fees. *Guardian Initial* _____

Doctor To be called:_____Phone: (_____)_____

Dentist To be called:_____Phone: (_____)_____

If possible, we prefer _____ Hospital

INSURANCE INFORMATION (Primary)

Insurance Co.: _____ Insurance Co. Phone: ( )

Policy Holder: _____ Date of Birth: _____

DISEASE/DISORDER/ILLNESS HISTORY: Please check any of the following that apply.

ADD or ADHD		Bone/Joint/Muscular Disorder		Heart Defect or Disease	
Allergies/Environmental		Cancer		Hepatitis or Liver Problem	
Allergies/Food		Developmental Disorder		Hypertension	
Allergies/Insect stings or bees		Diabetes (Type I or II)		Immune System Disorder	
Allergies/Latex		Dietary Restrictions		Mobility Limitation	
Allergies/Medications		Digestive/Bowel Disorder		Psychological/Mental Illness	
Allergies/Other:		Eating Disorder		Scoliosis	
Asthma/Breathing Disorder		Endocrine Disorder		Urinary/Bladder/Kidney Disorder	
Behavior Disorder		Epilepsy/Seizures		Surgery or Hospitalization	
Bladder/Kidney Disorder		Head or Spinal Injury		Vision or Eye Disorder	
Bleeding/Clotting Disorder		Hearing Problem			

Other conditions, not listed above: _____

_____

_____

_____

Please briefly describe **any additional information** regarding boxes checked in the list above:_____

_____

_____

_____

Has your child ever been **stung by a wasp/bee/flying insect?** (Circle one) **YES NO** Please describe their reaction both physically and emotionally: _____

_____

_____

MEDICATION HISTORY

Medication name:_____Used to treat:_____ Taken at school:____Yes*____No

Medication name:_____Used to treat:_____ Taken at school:____Yes*____No

Medication name:_____Used to treat:_____ Taken at school:____Yes*____No

**ALL medications, including inhalers and Epi-pens, must be kept in the school office. If your child needs to carry their inhaler or emergency medication with them, you must have an "Authorization to Self-Carry Form" completed by the physician on file. Medications that are going to be taken at school require "Medication Consent Forms" to be completed and returned to school. Over-the-counter medications need only parental/guardian consent. Prescription medications need consent from a parent/guardian and written consent by a health care provider. These forms can be obtained in the school offices or printed from the school website.*

CONSENT TO SHARE INFORMATION: The school nurse and/or health aide has my permission to share my child's confidential health information on a need-to-know basis, with appropriate members of the educational staff and primary healthcare providers for use in meeting the educational and health needs of my student. The consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance.

Parent/Guardian Signature:_____ Date:_____