Student Health & Emergency Information Sheet 2019-2020

OCMBOCES
Committed to Your Success

Student Name:_____ Home School _____

Address:_____
Street City State zip

Grade:_____ Age:_____ Date of Birth: _____

Mother/Parent/Guardian (1) Name: _____

_____ _____ _____
Home Phone Work Phone Cell Phone

Father/Parent/Guardian (2) Name: _____

_____ _____ _____
Home Phone Work Phone Cell Phone

Does Student Reside With You? Yes ___ No ___ Do you have Custody? Yes ___ No ___

Parent /Guardian EMAIL: _____

I authorize the following individuals to pick-up _____ from school if a parent /guardian
Student's Name
is not available:

_____
Name Relationship to Student Phone

_____
Name Relationship to Student Phone

EMERGENCY CONTACTS

It is vitally important that we have names of at least two (2) individuals whom we can call in the event of an emergency and when we are unable to contact you.

1st Contact: _____ Relationship: _____
Phone: _____ (home) Phone: _____ (work)
Phone: _____ (cell)

2nd Contact: _____ Relationship: _____
Phone: _____ (home) Phone: _____ (work)
Phone: _____ (cell)

3rd Contact _____ Relationship: _____
Phone: _____ (home) Phone: _____ (cell)

PLEASE COMPLETE HEALTH AND MEDICAL INFORMATION ON PAGE TWO.

Parent/Guardian Signature: _____ Date:_____

OFFICE USE ONLY: Program_____Instructor_____ am____ pm_____

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HEALTH HISTORY

Please check below any condition <u>currently</u> affecting your child *(detail below as needed)***:**

☐ Drug Allergy	☐ Asthma	☐ Heart Condition	☐ Recent Injury/Hospitalized
☐ Insect Allergy	☐ Uses an Inhaler	☐ Vision Problems	☐ Mental Health Condition
☐ Food Allergy	☐ Kidney Disease	☐ Hearing Problems	☐ Wears Glasses/Contacts
☐ Environmental Allergy	☐ Seizure Disorder	☐ Depression/Anxiety	☐ ADD/ADHD
☐ Has an Epipen	☐ Diabetes	☐ Back Injury/Disorder	☐ Autism Spectrum Disorder
☐ Concussion	☐ Other: _____		

Please list and explain any items checked above. Detail any additional illnesses, injuries and health problems your child has or is currently being treated for: _____

_____

_____

MEDICATIONS

Place check mark next to applicable:

_____ No Medications Taken _____ Receives Medication at Home _____ Receives Medication at School

Please list all medications taken on a regular basis:

Medication	Dosage/Frequency	Time Received	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

MEDICAL INFORMATION

Date of Last Tetanus Shot: _____ Hospital Preference:_____
Insurance Provider: _____ Insurance/Medicaid #: _____

Please list ALL doctors involved with your child, and their specialty (e.g. dentist, neurologist, cardiologist, dermatologist and etc.).

Doctor's Name	Specialty	Address	Phone	Date Last Seen