

The State of Ohio requires the Emergency Medical Form be updated annually

Homeroom #: _____

Student Information

Student Name:	<input type="checkbox"/> Male	Date of Birth:	Grade:
	<input type="checkbox"/> Female		
Student Address:	City/State:	Zip:	

Residential Parent/Guardian Information (please answer questions A, B, & C)

A. Student lives with (please X one): ____ Both Parents ____ Mother Only ____ Father Only ____ Other:	B. Status of Biological Parents (please X one): ____ Married ____ Divorced ____ Separated ____ Never Married ____ Widowed
C. Who has legal custody for child(ren)(please X one): ____ Both Parents ____ Mother Only ____ Father Only ____ Shared ____ Other:	<i>If separated or divorced, Custody papers are required for student file. For shared custody, please provide addresses of both parents below.</i>

Legal Parent/Guardian Information**Legal Parent/Guardian Information**

Name:	Name:
Cell Number:	Cell Number:
Home Number:	Home Number:
Email:	Email:
Relationship to Student:	Relationship to Student:
Is your address the same as the student? ____ Yes ____ No If NO, list your current address, city, state, & zip code:	Is your address the same as the student? ____ Yes ____ No If NO, list your current address, city, state, & zip code:

Emergency/Alternate Contacts

In the event you are unable to contact me at the above numbers, you have my permission to contact the following alternates. They have my permission to receive health care information regarding my child and can take my child home during school hours if needed.

Contact 1 (Other than Parent/Guardian)	Contact 2 (Other than Parent/Guardian)
Name:	Name:
Relationship:	Relationship:
Best Contact Number:	Best Contact Number:
Contact 3 (Other than Parent/Guardian)	Contact 4 (Other than Parent/Guardian)
Name:	Name:
Relationship:	Relationship:
Best Contact Number:	Best Contact Number:

Emergency Authorization

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the named doctor below, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does NOT cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Consent Given: ____ YES (if YES, please list "Medical Contacts" below) ____ NO (if NO, please give "Consent Refusal Instructions" below)

Physician Name:	Physician Phone:
Dentist Name:	Dentist Phone:
Medical Specialist:	Medical Specialist Phone:
Hospital Name:	Hospital Phone:

Facts concerning the child's history including allergies, medications being taken, and any physical impairments such as heart conditions, diabetes, epilepsy, etc., to which a physician or school staff should be alerted:

Consent Refusal Instructions:

Parent/Guardian Signature: _____ Date: _____

Boardman Local School District Health Information (School Year 20____ - 20____)

Student Name: _____ Grade: _____

Your child's health and education are very important to us. The information provided below will be used to facilitate your child's learning. Informing and educating staff about your child's needs will help promote his/her wellbeing. Confidentiality will be maintained and the information will be shared only with those responsible for meeting the child's health care needs.

1. Peanut Allergy?	___ Yes ___ No	Describe reaction: _____ Difficulty breathing? ___ Yes ___ No Emergency medication? ___ Yes ___ No Do you eliminate all peanut-containing food? ___ Yes ___ No
2. Other Food Allergy?	___ Yes ___ No	Food: _____ Describe reaction: _____ Difficulty breathing? ___ Yes ___ No Emergency medication? ___ Yes ___ No
3. Allergy?	___ Yes ___ No	Medications, seasonal or environmental? Please list: _____ Has allergy required emergency care in the past? ___ Yes ___ No Comments: _____
4. Sting Allergy?	___ Yes ___ No	Bee/insect? _____ Describe reaction: _____ Difficulty breathing? ___ Yes ___ No Emergency medication? ___ Yes ___ No
5. Diabetes?	___ Yes ___ No	DIABETES MANAGEMENT PLAN FROM DOCTOR AND SUPPLIES MUST BE IN THE NURSE'S OFFICE BY THE FIRST DAY OF SCHOOL.
6. Asthma?	___ Yes ___ No	Inhaler? ___ Yes ___ No <i>*If yes, inhaler must be kept in the nurse's office.</i>
7. Epilepsy/seizures?	___ Yes ___ No	Emergency Medication? ___ Yes ___ No
8. Heart Condition?	___ Yes ___ No	Describe: _____ Activity restrictions? ___ Yes ___ No Describe: _____
9. Other? (Any other health information you would like us to know about your child.)	___ Yes ___ No	Describe: _____ _____ _____

Please check ALL that apply regarding your child's vision and hearing:

Eyes: ___ Lazy Eye ___ Crossed ___ Difficulty Seeing ___ Glasses ___ Contacts
Ears: ___ Frequent Infections ___ Tubes ___ Hearing Difficulty ___ Hearing Aid for: ___ Right Ear ___ Left Ear

Daily Medications Taken by Student

Requirements for Medications to be administered at school:

- A. It is strongly recommended to parents, with their physician's counsel, that the medication schedule should be adjusted to avoid administering medication during school hours.
- B. If this is not possible, then the Medication Authorization Form must be filed with the respective building nurse's office before the student will be allowed to take medication during school hours. This written and signed request form is to be submitted each school year.

Name of Medication:	Reason for Taking:	Taken Where?
		Home and/or School
		Home and/or School
		Home and/or School

Any additional information regarding your child's health that should be brought to our staff's attention: _____

Parent/Guardian Signature: _____ Date: _____