

Hopkins Academy

Student Emergency Information Record

Name _____ Grade _____ DOB _____
Last First Middle Initial

Address _____
Street Town Zip Code

Mailing Address _____
(if different) Street Town Zip Code

Parent/Guardian #1 _____ Home Phone _____ Cell _____

Place of Employment _____ Work Hours _____ Phone _____

Home E-Mail _____ Work E-Mail _____

Parent/Guardian #2 _____ Home Phone _____ Cell _____

Place of Employment _____ Work Hours _____ Phone _____

Home E-Mail _____ Work E-Mail _____

Child Resides with _____

In an Emergency Contact (if parent/guardian cannot be reached):

1st _____ Relationship _____ Phone _____

2nd _____ Relationship _____ Phone _____

Child's Physician _____ Phone _____

Child's Dentist _____ Phone _____

ALLERGIES (including bee sting, drug, food) _____

I give permission for the school nurse (or delegated staff) to administer acetaminophen (Tylenol) to my child as needed during the school hours not exceeding 650mg in a day. Yes ___ No ___

I give permission for the school nurse (or delegated staff) to administer ibuprofen (Advil, Motrin) to my child as needed during the school hours not exceeding 400mg in a day. Yes ___ No ___

If the school is unable to reach a parent, in the event of a serious accident or illness, I hereby authorize the school to call my child's listed physician and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary. Yes ___ No ___

I give permission for the school nurse to share my child's diagnosis of hearing or vision problems, asthma, allergy, and/or food intolerance with appropriate school personnel as well as information relative to the prescribed treatment for his/her condition. Yes ___ No ___

Parent Signature

Date

Please note that the information on this side of the health record is confidential. While the opposite side of this record may be copied for field trips and provided to teachers, the following information is available only to the school nursing staff.

By answering these questions fully and honestly you enable the nursing staff to provide the best and most well-informed care for your child during school hours.

General Health Questions (please explain “yes” answers)

Has/does your child:

Condition	Yes	No	Comment if “Yes”
Had any recent injury, illness or infectious disease?			
Have a chronic or recurring illness or condition?			
Ever been hospitalized?			
Ever had surgery?			
Have frequent headaches?			
Ever had a head injury?			
Ever been knocked unconscious?			
Wear glasses, contacts or protective eye-wear?			
Ever passed out during or after exercise?			
Ever had seizures?			
Ever had chest pain during or after exercise?			
Ever had high blood pressure?			
Ever been diagnosed with a heart murmur?			
Ever had back problems?			
Ever had problems with joints?			
Have an orthodontic appliance?			
Have any skin problems?			
Have diabetes?			
Have asthma?			
Had mononucleosis in the past 12 months?			
If female, have an abnormal menstrual history?			
Ever had an eating disorder?			
Ever had emotional difficulties for which professional help was sought?			
Ever tried to harm self?			

My child’s health insurance is: _____ # _____
 (required information)

 Parent Signature Date