RETURN ORIGINAL TO NURSE

HEALTH SERVICES

2017 – 2018 Emergency/Medical Information

STUDENT'S NAME: _____ ID# _____ DOB:_____

Medicaid #: _____ ARKids First #: _____ Grade: _____

Address: _____
Address Apartment# City, State Zip

Parent/Guardian: _____ Phone#:_____

Father Works At: _____ Phone#: _____

Mother Works At: _____ Phone#: _____

Emergency Contact: _____Phone#: _____ Relationship: _____

Emergency Contact: _____Phone#: _____ Relationship: _____

Medical Doctor: _____ Phone#: _____

Dentist: _____ Phone#: _____

Medications: _____

Does your child have any of the following conditions? If so, please speak with the school nurse.

YES	NO		YES	NO	
___	___	Asthma	___	___	Frequent Ear Infections
___	___	Heart Disease	___	___	Glasses or Contacts
___	___	Seizures	___	___	Medication allergies (list)
___	___	Diabetes			_____
___	___	ADD	___	___	Other Allergies (list)
___	___	ADHD			_____
___	___	Other: _____			

Do you authorize emergency treatment if you cannot be reached? Yes ____ No ____

I understand that the above information may be released to appropriate Texarkana Arkansas School District employees and emergency personnel in order to facilitate health care. All Medical information will be kept strictly confidential.

_____ _____
Signature, Parent or Guardian Date