School Year 2018-2019 **GRADE_____**

Hemphill Independent School District P.O. Box 1950 Hemphill, TX 75948 409 787-3371 Fax 409 787-4137

Student Emergency Care and Health Form

_____, _____ _____ _____/_____
Last Name First Middle Age Birthdate

_____ _____
Mailing Address City/zip code

Mother/Guardian: _____ Home #_____ _____

Cell Phone: _____ Work Phone: _____

Father/Guardian: _____ Home # _____

Cell Phone: _____ Work Phone: _____

Student Lives With _____ Relationship _____

Other people who are authorized to pick up or transport my child if I am unable to be located:

_____/_____
Name Phone/ Relationship

_____/_____
Name Phone/Relationship

_____/_____
Name Phone/Relationship

Health Information

Check and Complete all that apply to your child.

____ **Allergies** – **List specifics below. IF ANY ARE LIFE-THREATENING, SEE SCHOOL NURSE.**

Food (list foods) - _____

Insect sting (list insects) - _____

Medication (list medications) - _____

Other (list) - _____

Reaction: cough hives rash local swelling wheezing difficulty breathing nausea generalized swelling other _____

Does your child need treatment for these allergies ***while at school*** – ⦿ NO ○ YES->SEE NURSE FOR FORM

*Oral antihistamine (Benadryl, etc.) *Epi-pen *Other _____

PARENTS MUST SUPPLY ALL MEDICATIONS

____ **ASTHMA** – (IF YOU CHECKED THIS SEE SCHOOL NURSE)

mild seasonal allergies exercise induced asthma occasional attacks severe attacks

Currently Prescribed Medications or treatments ***needed at school for asthma***

_____

Does student carry inhaler on self ***at school*** - ⦿ NO ○ YES->(SEE NURSE FOR FORM)

____ **DIABETES** – (SEE SCHOOL NURSE)

____ **SEIZURE DISORDER** – (SEE SCHOOL NURSE)

____ **OTHER HEALTH CONDITIONS** - (SEE SCHOOL NURSE)

Kidney disorder Heart/Blood disorder Cancer Cerebral Palsy Cystic fibrosis Hemophilia
Digestive Disorders Sickle Cell Disease Skin Disorders Speech Problems Physical Disability
Other _____

Is your child on any routine medications - ◉ NO ○ YES ->(SEE SCHOOL NURSE)
List _____

Will your child be taking any routine medication at school – ◉ NO ○ YES->(SEE SCHOOL NURSE)
List _____

Does your child require special procedures ***while at school*** ◉ NO ○ YES-> (check all that apply and SEE SCHOOL NURSE) catheterization oxygen gastrostomy care tracheostomy care
suctioning special diet other (Explain all boxes checked below):

_____
_____

____ VISION Conditions Contacts Glasses

____ HEARING Conditions If checked, does student wear Hearing Aids ○ YES ◉ NO

Hemphill ISD does not provide over the counter medications such as Ibuprofen, Tylenol, Creams, cough drops, etc. If you want your child to have medications at school the parent must bring them to the nurse's clinic in the original, labeled container and complete permission forms. **Any medications that expire while in the possession of the school clinic will be discarded.**

All/any of the above information may be provided to Hemphill ISD staff in order to keep each student's health and safety a top priority. This information will only be given to those teachers, coaches, and staff directly involved with the student and staff members are informed that all student information is confidential.

By signing below the parent agrees to the above information and also authorizes Hemphill ISD to use its judgment in securing the immediate care needed, including transportation in case of an emergency situation. Parent/Guardian accepts full responsibility for all charges incurred for these services.

Parent/Guardian _____ Date_____