

# KANAWHA COUNTY SCHOOLS HEALTH SERVICES

## Student Emergency Health Information

School \_\_\_\_\_

Student's Name \_\_\_\_\_ WVEIS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Grade \_\_\_\_\_ Home Room Teacher \_\_\_\_\_

Student's Address \_\_\_\_\_

Custodial Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Second Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Names and Grades of Brothers and Sisters \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list names and phone numbers of persons who may be contacted in the event a parent cannot be located. Only those listed below will be permitted to pick up your child in case of illness or emergency.

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name and Number of Medical Insurance \_\_\_\_\_

Current Health Issues: (Such as diabetes, seizures, asthma, etc.) \_\_\_\_\_

Health History: (Include past surgeries, serious illnesses, head injuries, etc.) \_\_\_\_\_

Medications: At Home \_\_\_\_\_

At School \_\_\_\_\_

Allergies: (Including those to insects, food, medications, environmental, etc.) \_\_\_\_\_

Reaction? \_\_\_\_\_ EpiPen? Yes \_\_\_\_\_ No \_\_\_\_\_

Restrictions: Describe any necessary restrictions or limitations. \_\_\_\_\_

Vision: Does your child wear glasses? \_\_\_\_\_ Describe any eye/vision problems. \_\_\_\_\_

Eye doctor (if student has one) \_\_\_\_\_ Phone \_\_\_\_\_

Hearing: Describe any hearing problems. \_\_\_\_\_

Ear doctor (if student has one) \_\_\_\_\_ Phone \_\_\_\_\_

The school nurse will keep this information in the nurse's office with other confidential documents. Signing below gives the school nurse permission to share the above information with other school personnel or Emergency Medical Services on a "need to know" basis.

Parent Signature: \_\_\_\_\_ Date \_\_\_\_\_