



Connecticut Technical Education and Career System--Health History & Emergency Contact Form

Student Name _____ Grade _____ Shop _____ Date of Birth _____ Male Female

Lives with: Both Parents Mother Father Legal Guardian: _____ Other: _____

Home Address: _____ Town _____ Zip Code _____

Emergency Contact Information: Names & grades of siblings attending this School: _____

Mother/Guardian's name: _____ Home Phone: _____

Address: _____ Town: _____ Zip: _____ Cell Phone: _____

Name of Employer _____ Work Phone: _____

Mother/Guardian's Email Address: _____

Father/Guardian's name: _____ Home Phone: _____

Address: _____ Town: _____ Zip: _____ Cell Phone: _____

Name of Employer _____ Work Phone: _____

Father/Guardian's Email Address: _____

If parent or guardian cannot be reached call:

1) Name: _____ Home # _____ Cell # _____ Work # _____ Relationship _____

2) Name: _____ Home # _____ Cell # _____ Work # _____ Relationship _____

3) Name: _____ Home # _____ Cell # _____ Work # _____ Relationship _____

Family Doctor's Name: _____ Phone # _____

Family Dentist's Name: _____ Phone # _____

Hospital Preference*: _____

*In the event of an emergency we will notify emergency personnel of your hospital preference. We cannot guarantee transport to a specific hospital.

Parent/Legal Guardian Signature: _____ **Date:** _____ **(Other Side Must Be Completed)**

Student's name: _____ Date of Birth _____ Shop _____

Is your child covered by Medical Insurance? Yes No

Medications taken at Home (**daily or as needed**): _____

Medications taken at School: _____

Allergies (**food, medication, insects, latex, other**): No Yes _____ EpiPen needed? No Yes

Asthma no yes If yes, mild moderate severe exercise induced? Inhaler needed: Yes No

I, _____ (Parent/Guardian name) give the school nurse permission to speak with my child's doctor about allergy and/or asthma management. Parent/Guardian Initials: _____ Date: _____

My child has or has had: Diabetes Seizures Brain or neurologic problem Head injury or concussion Bleeding disorder or bleeding that's very hard to stop Stomach or intestinal problems Heart problems Bone or joint problems Glasses Contacts Hearing Aid(s) Activity or gym restrictions (**requires doctor's note**) Problem with overeating or weight gain Problem with under-eating or weight loss ADD, ADHD or hyperactivity Depression Other psychological problem Frequent absences from school Problems in school Problems at home Other medical problem (s) _____

Please provide more information for any box checked above: _____

Parent/Legal Guardian Signature: _____ Date: _____

(Other Side Must Be Completed)

For School Nurse's Use Only: