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

Student Name -- Date of Birth ------------------ Grade ----------------- Shop -------------------- ◯Male ◯Female

Lives with: ◯ Both ◯ Parents ◯ Mother ◯ Father ◯ Legal Guardian Other: ------------------ Cell Phone: -------------------------------------

Home Address: -- Town: -- Zip Code: ---

Please list last School/ HS/College attended if any -- **Year of Graduation**: ---

Emergency Contact Information:

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 / Guardian cannot be reached call:

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

2)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: --

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/Post Grad name) give the school nurse permission to speak with my child's doctor about allergy and/or asthma management. Parent/Guardian/ Post Grad 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 undereating 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**: ---