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 a ---------- **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.

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 ◯ Frequentabsences from school ◯Problems in school ◯ Problems at home ◯ Other medical problem (s)

Please provide more information for any box checked above: ----------

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Permission to give Non-Prescription Medication: I understand that first aid ointments & cough/throat lozenges (if available) may be routinely administered to my student as specified in the district's standing orders. The School Nurse has my permission to administer the following medications *as ordered by the school district's Medical Advisor* on an "as needed" basis during the school day.

For "upset stomach" or heartburn: ◯Chewable antiacid (generic for TUMS)

For eye irritation ◯hydrating or lubricating eye drops (if available) ◯allergy eye drops (if available)

◯I do not want my child to receive any of these medications.

Please go to the school nurse website for additional forms for medical conditions require IECP needed for emergency staff medication

Parent/Guardian Signature: ---------- Date: ----------