EMERGENCY CONTACT AND HEALTH HISTORY FORM

OSSEO AREA SCHOOLS
ISD 279

OFFICE USE ONLY	STUDENT ID	NOTES

1. STUDENT INFORMATION

LEGAL NAME	LAST	FIRST	MIDDLE	GENDER	BIRTH DATE (mm/dd/yyyy) — —	ENR GRADE

2. EMERGENCY CONTACT INFORMATION

This information is being collected to provide for the student's health and safety at school. Refusal to supply emergency information could result in the school's inability to contact you in case of an emergency. In the event of an emergency and the school is unable to reach the parent, the school will secure emergency services (medical, dental, paramedic, ambulance) for my child, at parent expense. District Policy authorizes school staff to release private data to appropriate parties in connection with an emergency if the knowledge of the information is necessary to protect the health and safety of the student. I certify that all information below is accurate and that it is my responsibility to apprise the school of any changes in residency, phone numbers, and emergency release contacts.

BIOLOGICAL PARENT/LEGAL GUARDIAN/OTHER ADULT that lives with the student

LEGAL NAME	LAST	FIRST	MIDDLE	GENDER	RELATIONSHIP
HOME PHONE		CELL PHONE		WORK PHONE	
LEGAL NAME	LAST	FIRST	MIDDLE	GENDER	RELATIONSHIP
HOME PHONE		CELL PHONE		WORK PHONE	

PRIMARY EMAIL ADDRESS - Please list only one	DOCTOR/CLINIC NAME	DOCTOR/CLINIC PHONE NUMBER

OTHER EMERGENCY CONTACT(S) - If possible please list at least two contacts

LEGAL NAME	LAST	FIRST	MIDDLE	GENDER	RELATIONSHIP
HOME PHONE		CELL PHONE		WORK PHONE	
LEGAL NAME	LAST	FIRST	MIDDLE	GENDER	RELATIONSHIP
HOME PHONE		CELL PHONE		WORK PHONE	
LEGAL NAME	LAST	FIRST	MIDDLE	GENDER	RELATIONSHIP
HOME PHONE		CELL PHONE		WORK PHONE	

3. HEALTH HISTORY INFORMATION

This information is required in order to provide appropriate health services for your student. This data will be treated as private data and will be recorded in the student health record. It will be shared with those working with your child only on a "need to know" basis and with emergency personnel in the event of an emergency.

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CHRONIC HEALTH CONDITIONS? *(Check all that apply)*

- ☐ ADD/ADHD
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Other (Explain)
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Kidney Problems
- ☐ Sickle Cell Disease/Trait
- ☐ Tuberculosis
- ☐ Vision Loss
- ☐ Wheel Chair Type:

DOES YOUR CHILD HAVE ALLERGIES? LIST:
☐ Yes ☐ No

DOES YOUR CHILD HAVE AN EPI-PEN?
☐ Yes ☐ No
☐ Epi-Pen (Prescribed) - will be kept in the nurse's office
☐ Epi-Pen (Prescribed) - student will self-carry their Epi-pen

DOES YOUR CHILD HAVE ASTHMA?
☐ Yes ☐ No
☐ Inhaler/Neb (Prescribed) - will be kept in the nurse's office
☐ Inhaler - student will self-carry their inhaler

HAS YOUR CHILD BEEN HOSPITALIZED FOR ILLNESS, SURGERY, OR INJURY? IF YES, EXPLAIN:
☐ Yes ☐ No

DOES YOUR CHILD TAKE ANY MEDICATIONS? IF YES, LIST MEDICATIONS:
☐ Yes ☐ No

4. BIOLOGICAL PARENT/LEGAL GUARDIAN/OTHER PRIMARY CARE PROVIDER/EMANCIPATED STUDENT CERTIFICATION

I certify the information given above is true and complete to the best of my knowledge and belief.

Printed Name _____ Signature _____ Date _____