**STUDENT EMERGENCY RECORD**
**SOUTH TEXAS I.S.D.**

Grade: _____ ID#: _____ School Year: _____

DOB: _____ Entry Date: _____

_____

Last Name of Student First Name Middle Name

_____

Address City Zip Code

_____

Home Phone Emergency Phone Name Relationship

_____

Name of Father Occupation Business Phone Cell Phone

_____

Name of Mother Occupation Business Phone Cell Phone

_____ _____

Family Physician Choice of Hospital

## EMERGENCY MEDICAL AUTHORIZATION

I hereby authorize District employees to administer prescription, as well as nonprescription medication, when PROVIDED by me under the following provisions.

1. The District has received a written request to administer the medication from the parent, legal guardian or other person having legal control of the student.

2. When administering the medication, the medication must be in the original container and be properly labeled.

3. Medication obtained outside of the United States shall not be administered by district employees to students unless written authorization is on file from a physician licensed to practice in the United States.

I give authorization for the school to call the family physician and to follow the recommendations of the physician. I give authorization for an ambulance to be called, if necessary. I give authorization for another doctor to treat my child in case the family physician is not available. I give authorization for my child to be given the necessary medical attention in case the school cannot communicate with me. **I will not hold the school district financially responsible for the emergency care and/or transportation of my child**.

_____ _____

Parent/Guardian Signature Date

**List any medication your child is taking*:***

**At home** _____

**At school** _____

**All medication should be brought to the clinic on arrival to school. Medication should be brought to the clinic by the parent. Parents will complete proper forms when medication is dropped off**

Please Turn Over

South Texas ISD
Preparatory Academy
GRADES 7-8 | EDINBURG

Student Name: _____

DOB: _____ Grade: _____ ID#: _____ School Year: _____

**Has your child had any of the health problems listed below? Please explain if you answer yes.**

| **Condition:** | **Yes** | **No** | **Elaboration:** |
|---|---|---|---|
| **Allergy- Seasonal, Environmental, Food, medication.** | ☐ | ☐ | **to what?** |
| ***"Severe food allergy means a dangerous or life-threatening reaction of the human body to a food-borne allergen introduced by inhalation, ingestion, or skin contact that requires immediate medication attention. **If it is not listed, there will be an understanding that your child does not have any allergies.**** | | | |
| **Life threatening allergies/reactions?** | ☐ | ☐ | **to what?**<br>**Require medication?** |
| **Asthma – A doctor's written authorization is required to carry and self-administer asthma medication at school.** | ☐ | ☐ | **Has a doctor given approval for your child to carry and self-administer the medication in school?** |
| **Mental/Psychological Disorders** | ☐ | ☐ | **If yes, what disorder?**<br>**Require medication?** |
| **Birth defect** | ☐ | ☐ | |
| **Diabetes** | ☐ | ☐ | |
| **Chronic Ear Infection** | ☐ | ☐ | **Has tubes?** |
| **Hearing Problems** | ☐ | ☐ | **Hearing Aids?** |
| **Eye - Wears glasses or contacts?** | ☐ | ☐ | |
| **Other Disorders of the Eye** | ☐ | ☐ | |
| **Epilepsy/Seizures** | ☐ | ☐ | **Date of last seizure?** |
| **Hepatitis** | ☐ | ☐ | **Type:☐A ☐B ☐C** |
| **Kidney/Bladder Problems** | ☐ | ☐ | |
| **Rheumatic Fever** | ☐ | ☐ | |
| **Ulcers/Gastritis** | ☐ | ☐ | |
| **Orthopedic/Bone Problems?** | ☐ | ☐ | |
| **Heart Problems** | ☐ | ☐ | |
| **Doctor ordered restrictions?** | ☐ | ☐ | |

**Other Conditions or Comments**:_____
_____
_____