FRANCIS HOWELL SCHOOL DISTRICT
STUDENT HEALTH/EMERGENCY INFORMATION
PRESCHOOL

Revised 2/14

STUDENT'S LEGAL NAME

M F

Last Name | First Name | Middle Name | Gender

Student ID#: ________________________ Teacher/Grade: _________________ Date of Birth: _________________________
Address: ______________________________ City: __________________ Zip:_________ Home Phone:_____________________

Student Resides With: ____

Father, Step-Father, Guardian, Other. Name:____________________________________Work Phone:_____________________
Living in Home? ☐ Yes ☐ No Has permission to pick up from school? ☐ Yes ☐ No Cell Phone:_____________________

Mother, Step-Mother, Guardian, Other. Name:___________________________________Work Phone:_____________________
Living in Home? ☐ Yes ☐ No Has permission to pick up from school? ☐ Yes ☐ No Cell Phone:_____________________

Physician's Name:____________________________________ Phone: ___________________________________
Hospital Preference:____

In the event of an EMERGENCY or ILLNESS and parent/guardian cannot be reached, please provide the contact information for two people who will assume responsibility for your child. In case of a critical emergency, the Administrator or his/her designee will call 911 or appropriate emergency service and the parent/guardian. If the parent/guardian cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parents.

Name:____________________________________Relationship:____________________Day Phone:______________________

Name:____________________________________Relationship:____________________Day Phone:______________________

DOES YOUR CHILD HAVE:				IS YOUR CHILD DIAGNOSED WITH:			
	NO	YES	SPECIFY		NO	YES	SPECIFY
Seasonal Allergies	☐	☐		ADD	☐	☐	
Food Allergies	☐	☐		ADHD	☐	☐	
Drug Allergies	☐	☐		Anxiety	☐	☐	
Allergy requiring epi-pen	☐	☐		Autism	☐	☐	
Asthma	☐	☐		Bipolar	☐	☐	
Epilepsy/Seizures	☐	☐		Depression	☐	☐	
Diabetes	☐	☐		Emotional Condition	☐	☐	
Takes Insulin	☐	☐					
Heart Condition	☐	☐					
Skin Condition	☐	☐					
Chronic Ear Infection	☐	☐					
Ear tubes	☐	☐	IN OUT	Is your child currently under the care of a mental health provider?	☐	☐	
Kidney Disease	☐	☐		If so, who?			
Chronic Orthopedic Condition	☐	☐					

Has your child had a serious illness/hospitalization? ☐ NO ☐ YES
Specify:

Does your child wear glasses? ☐ NO ☐ YES Specify:

Does your child wear a hearing aid or cochlear implant? ☐ NO ☐ YES Specify:

Does your child take daily medication? ☐ NO ☐ YES Specify:____
Will your child require medicine at school? ☐ NO ☐ YES Specify:____

PRESCRIPTION AND OVER THE COUNTER MEDICATION to be given at school requires a written doctor's order and written parent permission along with the ORIGINAL bottle of medicine.

Guardian Signature________________________________Relationship:__________________________Date:______________