NURSES EMERGENCY INFORMATION 2023-2024
Old Rochester Regional School District

Student name: _____ **DOB:**_____
Full Address:_____
Teacher:_____ **Grade:**_____ **Bus #:**_____
Preferred Phone Number: _____

Parent/Guardian #1:_____
Employer:_____ Email:_____
Cell Phone: _____ Work Phone:_____
Parent/Guardian #1 Custody: ___Full ___Joint Other:_____

Parent/Guardian #2:_____
Employer:_____ Email:_____
Cell Phone: _____ Work Phone:_____
Parent/Guardian #2 Custody: ___Full ___Joint Other:_____

Does your child have health insurance? _____Yes _____ No
Health Insurance Company:_____ Policy number:_____

Please indicate names of others who are allowed to pick up your child, will assume responsibility, and provide transportation for your child in case of illness/injury/emergency:

Name:_____ Relationship to student:_____ Daytime Phone:_____

Name:_____ Relationship to student:_____ Daytime Phone:_____

Name:_____ Relationship to student:_____ Daytime Phone:_____

Student Physician:_____ Phone:_____
Student Dentist: _____ Phone:_____

I give the school nurse my permission to administer the following medications in school if needed (please initial next to each medication you give a nurse permission to administer in school):

Tylenol ____ Ibuprofen_____ Hydrocortisone Cream____ Calamine Lotion____ Antibiotic Ointment _____

Please place a checkmark next to the following conditions that pertain to your child:

__ Heart Condition __ Diabetes __ Seizure Disorder __ ADD/ADHD __ Anxiety __ Depression __ Hearing Problems
__ Vision Problems __ Asthma __Other (Specify)_____
__ Allergies (Specify: food, medicine, insects, environment) _____
__ Medication (s) (Specify) _____

I understand that this information is confidential, however, federal law permits information in the school health record to be shared with school officials on a 'need to know' basis and with a very limited number of other persons, including those who may need to help in an emergency. In other circumstances, my consent will be required. I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.

Parent/Guardian Signature: _____ Date: _____