Pittsford Schools

Please check this box if you would prefer a fully remote ESY program (if available). ☐

Medical Update and Emergency Contact Information
To be completed by the Parent and returned to the ESY Program by May 12

Student Name_____ Sex ____ DOB _____ Grade _____ Age _____ Home School_____

Mother_____ Home Phone _____ Cell Phone _____

Father _____ Home Phone _____ _____ Cell Phone _____

Emergency Contacts/ Authorized Person(s) for pick-up in addition to parents:

Name _____ Relationship_____ Phone _____

Name _____ Relationship_____ Phone _____

Medical History:
Does your child have any medical or developmental condition? yes ☐ no ☐ If yes, please describe.

_____

_____

3. Does child take any daily medications? yes ☐ no ☐ Please list all medications below. Use back of form if needed.
*Name/s _____
Will this medication need to be given during the ESY Program, at school? yes ☐ no ☐ or camp? yes ☐ no ☐
4. Does your child see a specialist? yes ☐ no ☐ Specify _____
5. Has your child ever had a serious illness/injury that: required hospitalization? yes ☐ no ☐ Specify_____
Required an operation? yes ☐ no ☐ Specify_____
Had a bone or muscle injury? yes ☐ no ☐ Specify_____
Has your child ever had an injury that required an emergency room visit? yes ☐ no ☐
For what _____ When _____
3. Any allergies to food, medication or serious environmental allergies? yes ☐ no ☐ If yes, to what? _____
Have an Epi-pen? yes ☐ no ☐ Benadryl? yes ☐ no ☐
4. Has you child ever "passed out", had a concussion or serious head injury? yes ☐ no ☐
5. Has child ever had a seizure/convulsion? yes ☐ no ☐
If yes, date of last seizure _____ Did your child go to the hospital? yes ☐ no ☐
8. Does child wear glasses or contacts? yes ☐ no ☐
Specify_____
9. Does your child need assistance with toileting? yes ☐ no ☐ Specify_____
10. Does your child have any serious fears? yes ☐ no ☐ If Yes, Please describe _____

_____

DOCTOR/HOSPITAL INFO:

Doctor _____ **Phone** _____
Dentist _____ **Phone** _____
Preferred Hospital _____

Any additional comments, notes or alerts: _____

Please sign below giving

1. Permission for the Nurse to share my child's Emergency Medical Information to appropriate staff, such as but not limited to, Allergies to Food, Latex, Insects or Environment, Seizure Disorder, Asthma Diabetes: yes ☐ no ☐
2. Permission for the PCSD ESY Staff to take photographs/video of my child to be used in our program and for the end of the summer program video unless otherwise indicated: yes ☐ no ☐

Parent/Guardian Signature_____ **Date**_____

This form may be returned electronically to SPED_ESY@pittsford.monroe.edu