



**Antilles
SCHOOL**
Excellence Diversity Community

OFFICE OF SCHOOL NURSE

7280 Frenchman's Bay

St. Thomas, VI 00802

340-776-1600 x 4603

FAX: 340-776-1019

nurse@antilles.vi

2024-2025

EMERGENCY HEALTH INFORMATION FORM

Information on this form will be shared with school personnel directly involved with your child's education, unless you indicate otherwise.

Student's Last Name: _____ First Name: _____ Middle: _____

Student Usually Called _____

Grade: _____ Date of Birth: _____ Age: _____ Sex: _____

Mailing Address: _____ Cell Phone: _____

Family Physician Name: _____ Physician's Phone: _____

Family Dentist's Name: _____ Dentist's Phone: _____

Emergency Contacts:

First Contact Parent/Guardian:

Second Contact Parent/Guardian:

Name: _____

Employer: _____

Daytime Phone: _____

Cell Phone: _____

Email: _____

In case of emergency, if a parent/guardian cannot be reached, notify:

1. _____ Phone: _____

2. _____ Phone: _____

ALLERGIES: Please list ALL allergies including food and drug:

If your child has a health condition(s), which may require EMERGENCY ACTION while at school (e.g., seizures, insect sting allergy, asthma, bleeding condition, sickle cell, diabetes, heart condition, peanut allergy, other), please use the space below to provide detailed information. Please indicate if they carry an inhaler or EpiPen.

Continue on back. Thank you for completing.

Antilles School attempts to discourage distribution of medication while students are at the school. If your physician determines it is necessary for your child to receive prescription medication during the hours your child is in attendance at Antilles, the specific directions and approval accompanied by physician's signature must be provided on the Prescription Medication Release Form prior to dispensing of any prescription medication. For your child's safety, it is recommended that first dosage of any medication be administered with the physician or at home.

Please send all medication(s) to the Antilles School Nurse in its original box or bottle with a current prescription label on the container. Pharmacists will assist when necessary to provide a "duplicate" container for this purpose.

2024-2025 School Year

Student's Last Name: _____ First Name: _____ Middle: _____

I/WE hereby grant my/our express permission for the Antilles School Nurse or other School Personnel to administer non-prescription, over-the-counter medication(s) on an as needed basis to my child during the school day for such common ailments as headache, menstrual cramps, fever, rash, etc. (All over-the-counter medications are age appropriate)

***Please check one of the following:**

☐ YES, my child can receive treatment and have OTC medications at school (this includes bug spray and sunscreen).

☐ YES, my child can receive treatment and have OTC medications at school with the exception of the following:

☐ NO, my child cannot have OTC medications at school.

☐ NO, my child cannot be treated at school.

☐ NO, my child cannot have OTC medications at school, with the exception of hurt-free antiseptic wash and triple antibiotic ointment for cuts and ice packs in the event of an injury at school.

In the event that I/We am/are unable to be contacted during an emergency situation for my/our child, I/We hereby give my/our express permission for Antilles School to admit my child for emergency treatment to the hospital or other medical facility. I also give Antilles School Nurse or other School Personnel permission to administer Emergency Epinephrine in the form of an Auto-Injector Pen in an allergic emergency/anaphylaxis.

***Please check one of the following:**

☐ YES

☐ NO

Parent/Guardian Signature

Date

Parent/Guardian Print

Date
