## STUDENT EMERGENCY RECORD

Always Innovating

|  | List ony m   | edication your c  | hild is taking:  |                   |  |
|--|--|---|--|-------------------|--|
| Parent/Guardian Signature  |  |   | Date   |                   |  |
| under the following  1. The District has a having legal contro  2. When administed  3. Medication obtain authorization is on  I give authorization authorization for a family physician is | g provisions. The received a written request to add a lof the student.  The ring the medication, the medication of the United State file from a physician licensed to a loft the school to call the faminambulance to be called, if necessate with me. I will not hold to the service of the will not hold to the service of the will not hold to the service of the service o | minister the medication must be in the or es shall not be administ practice in the United mily physician and to excessary. I give authorion for my child to be gi | iginal container and be<br>tered by district emplo<br>States.<br>Follow the recommend<br>zation for another doc<br>ven the necessary med | properly labeled. |  |
| Family Physi   | EMERGENO   | CY MEDICAL AU   |  |                   |  |
| ame of Mother  | Occupation   |   | ness Phone   | Cell Phone        |  |
| ame of Father  | Occupation   | Bus   | ness Phone   | Cell Phone        |  |
| ome Phone  | Emergency Phone  | Nar   | ne   | Relationship      |  |
| ddress   |  | ity   | Zip Code   |                   |  |
| ast Name of Student  |  | First Name  |  | Middle Name       |  |
|  |  |   |  |                   |  |
| OB:  |  | RIO GRANDE VALL   | EY   GRADES 6-12   | Entry Date:       |  |

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

## Student Emergency Record - Page 2



| Student Name:   | Y   GRADES 6-12 |    |   |  |  |  |
|---|-----------------|----|---|--|--|--|
|   |                 |    |   |  |  |  |
| 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:  |  |  |  |
| Condition.  | 163             | NO | Liaboration.  |  |  |  |
| 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?  |  |  |  |
|   |                 |    | Require medication?                                 |  |  |  |
| Asthma – A doctor's written authorization is required   |                 |    | Has a doctor given approval for your child to carry |  |  |  |
| to carry and self-administer asthma medication at school.   |                 |    | and self-administer the medication in school?       |  |  |  |
| Mental/Psychological Disorders  |                 |    | If yes, what disorder?                              |  |  |  |
|   |                 |    | 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:   |                 |    |   |  |  |  |
|   |                 |    |   |  |  |  |