Revised 4/21/16

HERTFORD COUNTY PUBLIC SCHOOLS

Teaching Children ~ Touching the Future

Student Emergency Information
2016-2017

Name:_____
Last *First* *Middle*

Address *(include city and zip code):* _____

Birth date: _____ **Home Phone:** _____ **Grade:** _____

School: _____ **Teacher/Homeroom** _____

Transportation from school: **Bus#**_____ **Walk** _____ **Carpool** _____

Student lives with: ❒ **parent(s)** ❒ **guardian(s)** **Person responsible for picking up child** _____

Mother's Name: _____ **Phone:** _____

Mother's Place of Employment:_____ **Phone:**_____

Father's Name: _____ **Phone:** _____

Father's Place of Employment:_____ **Phone:**_____

Guardian's Name: _____ **Phone:** _____

Guardian's Place of Employment: _____ **Phone:** _____

List two neighbors or relatives who can assume temporary care of your child if you cannot be reached.

1. **Name:** _____ **Phone:** _____ **Relation to Student:** _____
2. **Name:** _____ **Phone:** _____ **Relation to Student:** _____

In case of a medical emergency, injury or serious illness, school personnel will try to reach me personally. If unable to do so, I hereby authorize school personnel to take or send my child to the family physician, dentist, or the hospital. If it is impossible to reach either me or the physician/dentist/specialist indicated, the school may seek emergency care elsewhere at the expense of the parent/guardian.

_____ _____
Parent/Guardian's Signature **Date**

Name of Siblings	School They Attend

Hospital Preference: **Vidant Roanoke-Chowan Hospital***
**Note: Hertford County Schools refers students only to Vidant Roanoke-Chowan Hospital since it is the only such facility in the county.*

I give my permission to the School Health Nurse to share or receive health-related information needed to care for my child with other healthcare providers (for example: doctor, dentist, eye doctor) during the 2016-2017 school year. ❒ Yes ❒ No

_____ _____ _____
Parent/Legal Guardian's Signature **Date** **Daytime Phone Number**

Please See Reverse Side

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Student Health Information

(Circle YES or NO for each of the following)

Chronic Condition	Yes	No
Attention Deficit Hyperactivity or Attention Deficit	Yes	No
Allergic to:(*Please specify*)		
Food	Yes	No
Seasonal	Yes	No
Other	Yes	No
Anorexia/Bulimia	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Bladder Issues	Yes	No
Bleeding Disorder	Yes	No
Cancer/Leukemia	Yes	No
Cerebral Palsy	Yes	No
Cystic Fibrosis	Yes	No
Diabetes	Yes	No
Down's Syndrome	Yes	No
Epilepsy	Yes	No
Epistaxis (Nosebleeds	Yes	No

Chronic Condition	Yes	No
Feeding Problems	Yes	No
Genetic Disorders	Yes	No
Heart Issues	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
Kidney Disease	Yes	No
Menstrual Problems	Yes	No
Mental Health Disorder	Yes	No
Migraines	Yes	No
Multiple Sclerosis	Yes	No
Muscular Dystrophy	Yes	No
Obesity	Yes	No
Orthopedic Problems	Yes	No
Seizures	Yes	No
Sickle Cell Anemia	Yes	No
Stomach Problems	Yes	No
Tuberculosis	Yes	No

Other conditions: *(Be specific)*	Comments:

Has your child had a head injury/concussion in the past year?	*Yes*	*No*
If yes, is the child still under medical care/supervision	*Yes*	*No*

Medication Information	Yes	No	Describe
Does your child take medication(s) daily?			
Does your child need medication at school? *If your child needs medication at school, you must request a medication authorization form.			
I need a medication authorization form.			

***Please note:** *If your child needs to take ANY medication (prescription or over the counter) at school, an "Authorization for Medication During School Hours" form must be completed and on file at the school. This form can be obtained from the school office and must be submitted each school year. All medication is to be brought to school by an adult, not sent with the student or bus driver.*