2020-21
RANDOLPH COUNTY SCHOOLS
STUDENT INFORMATION/EMERGENCY MEDICAL INFORMATION FORM

Please use black/blue ink. Complete both sides.

STUDENT NAME_____ _____ _____ __ MALE __ FEMALE GRADE_____
Last First Middle

WVEIS# _____ **BIRTHDATE (MM/DD/YY)** __ __/__ __/__ __ **BIRTH PLACE (CITY, STATE)** _____ _____

HOME PHONE__ __ __-__ __ __- __ __ __ __ **UNLISTED** ___**YES** ___**NO** **CELL**__ __ __-__ __ __-__ __ __ __

TRANSFERRED FROM_____ **TRANSPORTATION**_____ **BUS NUMBER(Morning)**_____ **(Evening)**_____
01=Bus Student; 02=Non Bus Student

NATIVE LANGUAGE:_____ **ETHNIC GROUP:**_____
Arabic, Chinese Mandarin, English, Somali, Spanish, Thai, Vietnamese Hispanic, White, Black, Asian, Amerind, Pacific

HOME (Physical) ADDRESS_____
Box/Street Name/Number/Apartment Number (Example: 123 Brown Street)

MAILING ADDRESS (if different)_____ _____ _____
City State Zip Code

PARENT/GUARDIAN_____ _____**Phone** __ __ __- __ __ __-__ __ __ __
Active Duty Military ____ **YES** ____ **NO** **Cell** __ __ __- __ __ __-__ __ __ __

ADDRESS_____ **Email (optional)**_____

EMPLOYER_____ **Phone** __ __ __- __ __ __-__ __ __ __ **EXT.** __ __ __ __

PARENT/GUARDIAN_____ _____**Phone** __ __ __-__ __ __-__ __ __ __
Active Duty Military ____ **YES** ____ **NO** **Cell** __ __ __-__ __ __-__ __ __ __

ADDRESS_____ **Email (optional)**_____

EMPLOYER_____ **Phone** __ __ __- __ __ __-__ __ __ __ **EXT.** __ __ __ __

→ **Student lives with: (List ALL ADULTS and relation to student)**
_____ **Both Parents** _____ **Father** _____ **Mother** _____ **Step-Father/Mother** _____**Other***

***If Other, please explain and give name of person other than parent:** _____

List First/Last names of other school-age children in this student's household:

_____ _____

_____ _____

→ **Please identify persons other than parent or guardian who could be contact in case of an emergency:**

NAME (Last, First, Middle) _____ **Relationship** _____ **PHONE** __ __ __-__ __ __-__ __ __ __

NAME (Last, First, Middle) _____ **Relationship** _____ **PHONE** __ __ __-__ __ __-__ __ __ __

PHYSICIAN _____ **PHONE** __ __ __-__ __ __-__ __ __ __ **DATE OF LAST EXAM** _____

DENTIST _____ **PHONE** __ __ __-__ __ __-__ __ __ __ **DATE OF LAST EXAM** _____

→ **IF STUDENT IS COVERED BY PRIVATE HEALTH INSURANCE, PLEASE PROVIDE INSURANCE INFORMATION:**

INSURANCE COMPANY _____ **GROUP NUMBER** _____
NAME OF INSURED _____ **ID NUMBER** _____
MEDICAID # _____ ****Please complete both sides****

STUDENT'S CURRENT HEALTH CONDITION AS DIAGNOSED BY A PHYSICIAN

Check if any of the following conditions apply to your child:

1. __ Anorexia/Bulimia
2. __ Arthritis – Juvenile Rheumatoid
3. __ Asthma – Prescribed Inhaler Y__ N__
4. __ Autism
5. __ Bleeding/Coagulation Problem
6. __ Cancer
7. __ Cerebral Palsy
8. __ Crohn's Disease
9. __ Cystic Fibrosis
10. __ Diabetes
11. __ Depression (under physician's care)
12. __ Other Emotional/Psychological Problems (Under Physician's Care)
13. __ Heart Problems
14. __ Hyperactive/ADHD/ADD – Prescribed Meds Y__ N__
15. __ Hypoglycemia (Low Blood Sugar) NOT related to diabetes – Requires snack *Requires: Physician's Order*
16. __ Intestinal Problems (Other than Crohn's)
17. __ Leukemia
18. __ Mentally Impaired
19. __ Migraine Headaches
20. __ Orthopedic Problems
21. __ Prosthesis
22. __ Scoliosis
23. __ Seizure Disorder Date of last seizure _____
24. __ Spina Bifida
25. __ Stomach Problems
26. __ Tourette's Syndrome
27. __ Urinary Tract Problem (Ex: Kidney/Bladder Problems as diagnosed by a physician)
28. __ Frequent ear infections with related hearing loss
29. __ Hearing Loss: __ Uses Hearing Aids ___ Left ___ Right ___ Has Tubes in Ears ___ Left ___ Right
30. __ Vision problem: ___ Glasses ___ Contacts ___ Color Blind ___ Other (Please Explain) _____
31. __ Allergies: ___ Seasonal/Environmental ___ Food ___ Medications

→ Please list and describe symptoms and severity: _____

_____

32. __ Does your child have a SEVERE reaction with breathing and swallowing difficulties requiring an IMMEDIATE INJECTION OF MEDICATIONS? ___ YES ___NO *SPECIFY ALLERGY _____
If yes, please bring an auto-injector EPI-PEN to school for your child along with a physician's order and directions.
*Date of last occurrence: _____

→ Please give more details about any health problem you have checked above and indicate any special instructions related to it: _____

_____

Describe any OTHER health problem NOT LISTED above and indicate any special instructions related to it:

_____

List any activity restrictions: _____

List any daily medication(s) taken by your child: _____

_____

→ **Will student need to take this medication at school? ___ YES ___NO**

→ **Will student need any special modifications or health care related to above described health problems? ___ YES ___ NO**

If YES, schedule a meeting with the principal and school nurse. Provide a written request and instructions and a physician's order as appropriate.

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→ **PRINCIPALS AND TEACHERS HAVE NO AUTHORITY TO GIVE MEDICINE OF ANY KIND TO A STUDENT WITHOUT WRITTEN PARENTAL PERMISSION.**

→ **RANDOLPH COUNTY SCHOOLS PROVIDES NO OVER-THE-COUNTER MEDICATIONS FOR STUDENTS FOR RELIEF OF HEADACHES, STOMACH ACHES, ALLERGIC REACTIONS, ETC.**

ANY MEDICINE INTENDED FOR STUDENT USE DURING SCHOOL HOURS MUST BE BROUGHT TO SCHOOL BY THE PARENT.

(1) ALL MEDICATIONS WILL REQUIRE A PHYSICIAN'S ORDER.

(2) ALL MEDICINE MUST BE IN ITS ORIGINAL CONTAINER AND PROPERLY LABELED.

(3) PARENT MUST FILL OUT AND SIGN A REQUEST FOR ADMINISTRATION OF MEDICINE FORM. THE MEDICINE WILL NOT BE GIVEN WITHOUT THIS FORM.

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I, _____ (DO___) (DO NOT ___), authorize my child's health care provider and designated provider of healthcare in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place for the current school year.

***In the event of an emergency, and if the parent/guardian or alternate contact cannot be reached, the school may judge that it is necessary to call emergency medical services and have the student transported to the hospital for treatment at the parents' expense.**

I GIVE THE SCHOOL PERSONNEL, PHYSICIAN AND HOSPITAL MY PERMISSION TO RENDER SUCH TREATMENT AS MAY BE DEEMED NECESSARY IN AN EMERGENCY TO PROTECT THE HEALTH AND WELFARE OF MY CHILD.

→ **Signature of Parent/Guardian** _____ **Date** _____