FORM A
Side 1

PERMISSION FOR EMERGENCY CARE

To be completed annually by parent/guardian

Student's Last Name _____ First Name _____ Nickname _____ Grade ____

Address _____
Street City State Zip

Student's Date of Birth ____/____/____ ☐ Male ☐ Female Home Phone (_____)_____

Father's Name _____ Work Phone (_____)_____ Hours _____

Father's Email Address _____ Cell/Pager (_____)_____

Mother's Name _____ Work Phone (_____)_____ Hours _____

Mother's Email Address _____ Cell/Pager (_____)_____

Father's Address (if different) _____
Street City State Zip

Mother's Address (if different) _____
Street City State Zip

Father's Workplace and Address _____

Mother's Workplace and Address _____

Name(s) of person(s) or agency having legal custody* _____
*If not parent, appropriate custody paperwork must be attached.
Address (if not parent)_____

Persons NOT authorized to pick up child from school** Name _____

Relationship _____ **If parent, appropriate custody paperwork must be attached.

Child's Doctor _____ Office Phone (_____)_____

Current Medical Conditions (e.g. diabetes, heart disease, contact lenses, hearing aids, etc.) _____

_____

Child's Allergies (if any) _____ Action to Take _____

Medication(s) Child is Taking _____ Date of Last Tetanus Shot _____

Health Insurance Company _____ Policy Number _____

Emergency Contacts: In the event a parent/guardian cannot be reached, you **must give** the name, address and phone number of two persons who could pick up and take your child home in a timely manner.

1. _____
Full Name Relationship Address Phone

2. _____
Full Name Relationship Address Phone

I agree to notify the school within 24 hours if my child or any member of my immediate household has developed a communicable disease. I agree to notify the school immediately if the disease is life threatening. I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, the above emergency contacts can be called to pick up my child. Additionally, if I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child.

Parent/Guardian Signature _____ Date _____

FORM A
Side 2
CONFIDENTIAL STUDENT HEALTH HISTORY UPDATE

PARENT/GUARDIAN: **Please complete this form at the beginning of each school year.**

Name	Sex: ☐M ☐F DOB	School	Grade
Mother / Guardian	Work #	Home #	Cell #
Father / Guardian	Work #	Home #	Cell#
Physician		Phone#	School Year

Complete the following checklist by indicating any of the following student conditions, past or present.

	YES*	NO	DATE
Allergies / Environmental	☐	☐	
Allergies / Food	☐	☐	
Allergies / Insect Stings or Bees	☐	☐	
Allergies / Latex	☐	☐	
Allergies / Medications	☐	☐	
Allergies / Other	☐	☐	
Asthma / Breathing Problem	☐	☐	
Behavioral Problem	☐	☐	
Bladder / Kidney Disorder	☐	☐	
Bleeding / Clotting Disorder	☐	☐	
Bone / Joint/Muscular Disorder	☐	☐	
Cancer	☐	☐	
Convulsions / Epilepsy / Seizure	☐	☐	
Dental Problem	☐	☐	
Developmental Problem	☐	☐	
Dizziness or Fainting	☐	☐	
Diabetes	☐	☐	
Dietary Restriction	☐	☐	
Digestive / Bowel Problem	☐	☐	
Eating Disorder	☐	☐	
Endocrine Disorder	☐	☐	
Head or Spinal Injury	☐	☐	
Headaches / Migraines	☐	☐	

	YES*	NO	DATE
Hearing Problem	☐	☐	
Heart Defect or Disease	☐	☐	
Hepatitis or Liver Problem	☐	☐	
Hernia	☐	☐	
Hypertension	☐	☐	
Immune System Disorder	☐	☐	
Infectious Disease, Current	☐	☐	
Infectious Disease, Inactive	☐	☐	
Lead Poisoning	☐	☐	
Menstrual Problem	☐	☐	
Mobility Limitation	☐	☐	
Mononucleosis	☐	☐	
Orthodontic Treatment	☐	☐	
Physical Education Restriction	☐	☐	
Psychological / Emotional Problem	☐	☐	
Scoliosis	☐	☐	
Skin Condition	☐	☐	
Soiling / Incontinence	☐	☐	
Speech Disorder	☐	☐	
Surgery or Hospitalization	☐	☐	
Tuberculosis	☐	☐	
Vision or Eye Disorder	☐	☐	
Other: (explain below)	☐	☐	

*Provide details for all items above marked ***YES*** :

Does the student's health condition require medically necessary medications or specialized health care treatments in school? ☐ YES ☐NO Explain

Does the student take any medications, homeopathic supplements, or nutritional & performance supplements? ☐ YES ☐NO Explain

Specifically ***during or after exercise,*** has the student experienced any of the following? Check all that apply:

☐Fainting / Passing-Out ☐Heat Stroke ☐*Severe* Lightheadedness / Dizziness ☐Coughing / Wheezing ☐Excessive Bruising

☐*Extreme* Shortness of Breath ☐Chest Pain ☐Numbness / Tingling in_____ ☐NONE APPLY

Was a Medical Evaluation done as a result of any of the above symptoms during exercise? ☐YES ☐NO Outcome:

☐**YES** ☐**NO** **CONSENT FOR TREATMENT:** I give my permission for qualified school personnel to provide routine health care and first aid to my child as may be necessary during school and after school activities. I assume full responsibility for providing the school with all necessary student over-the-counter or prescription medications as well as necessary medical treatment supplies and authorizations.

☐**YES** ☐**NO** **CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide have my permission to share my child's confidential health information, on a need to know basis, with appropriate members of the educational staff, primary healthcare providers and extended day, for use in meeting the educational and health needs of my student. This consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance audits by the Virginia Department of Health, and the Virginia Department of Social Services for licensed program compliance, if applicable.

Parent / Guardian Signature_____Date_____