MEDINA CENTRAL SCHOOL DISTRICT
BOARD OF EDUCATION OFFICE
One Mustang Drive
Medina, New York 14103-1845
(585) 798-2700 Fax: (585) 798-3108

www.medinacsd.org

Mark Kruzynski
Superintendent of Schools

DATE: _____ TEACHER: _____ GRADE: _____

HEALTH AND EMERGENCY INFORMATION

STUDENT'S NAME: _____ BIRTHDATE: _____

STUDENT RESIDES WITH: ( ) both parents ( ) mother ( ) father ( ) other (please specify) _____

ADDRESS: _____ BUS NO. _____ AM _____PM
Street Town Zip

TELEPHONE (Home): ( ) _____ Nearest Phone (if no home phone): ( ) _____

MOTHER: _____ _____ ( ) _____
ADDRESS (if other than student) CELL PHONE

MOTHER'S EMPLOYER: _____ PHONE: ( ) _____

FATHER: _____ _____ ( ) _____
ADDRESS (if other than students) CELL PHONE

FATHER'S EMPLOYER: _____ PHONE: ( ) _____

LEGAL GUARDIAN: _____ _____ ( ) _____
(If other than parent) ADDRESS (if other than students) CELL PHONE

****Legal verification of guardianship is necessary if other than parent. Custody papers are required and must be updated every year.****
CUSTODY ISSUES? Yes _____ No _____Please explain: _____

_____

EMERGENCY CONTACT PERSON (These contacts will assume responsibility/transportation in absence of parent/guardian.)

1. _____ PHONE: ( ) _____

2. _____ PHONE: ( ) _____

OTHERS LIVING IN YOUR HOME:

	Name	Age	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

HEALTH INFORMATION: List all health conditions which require special handling in an emergency, which may affect your child's performance in school, or that would be important for the nurse to know:

_____

_____

PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

HEART CONDITION DIABETES ASTHMA SEIZURE DISORDERS MIGRAINES

ADD ADHD OTHERS-PLEASE SPECIFY_____

ALLERGIES: _____REACTION? _____EPIPEN? _____

MEDICATIONS: _____
(Include Inhalers/Insulin/Antidepressants/Cardiac/Behavioral medications etc.)

PHYSICIAN'S NAME: _____ PHONE: ( ) _____

DENTIST'S NAME: _____ PHONE: ( ) _____

Does your child wear glasses or contact lenses? _____
Does your child have a hearing aid or loss of hearing? _____
Are there any family circumstances which might have an impact on your child's school performance?
_____
*This information is kept in your child's confidential medical file and is shared only with appropriate members of the teaching team. You are invited to call or make an appointment with the School Nurse to discuss any sensitive information if you prefer.

CONSENT FOR EMERGENCY TREATMENT

In case of serious illness or the accident injury of my child, I request school personnel to contact me. If the school is unable to reach me or the emergency persons listed above, I hereby authorize officials of the Medina Central School District to make any arrangements deemed necessary for the emergency care of my child.

You must have a written physician's order for your child to take medication at school. This includes prescription medication such as inhalers, EpiPens, and over the counter medication including but not limited to cough drops, triple antibiotic ointment, hydrocortisone, cough syrup, Anbesol/Orajel, anti-fungal cream, topical analgesics, acetaminophen and ibuprofen. The school nurse will NOT dispense any medication without a written MD order and written parental consent._____

_____ _____ _____ _____
Mother's (Female Legal Guardian's) signature **Date** **Father's (Male Legal Guardian's) signature** **Date**

CONSENT TO SHARE INFORMATION

I give permission to the school nurse/designee to share information relevant to my child's condition with appropriate personnel when needed to meet my child's health and safety needs.
I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

A CURRENT PHYSICAL EXAMINATION REPORT SHOULD BE ON FILE AT ALL TIMES.

_____ _____ _____ _____
Mother's (Female Legal Guardian's) signature **Date** **Father's (Male Legal Guardian's) signature Date**