Immaculate Conception School
Medical Information and Emergency Form
2020-2021

Place student's sticker here.
To include Name, DOB, Grade

Student's name:

Grade:

Name of Parent/Guardian**#1**: _____ Relationship: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work #: (_____) _____ - _____

Place of Employment: _____ Occupation: _____

Email Address: _____

Name of Parent/Guardian**#2**: _____ Relationship: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work #: (_____) _____ - _____

Place of Employment: _____ Occupation: _____

Email Address: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

- **Does your child have ANY allergies: ☐ YES ☐ NO**

If **YES**, please list **ANY** and **ALL** allergies to include medications, food, environmental, bee stings, etc…

_____

_____

- **Does your child require an EpiPen: ☐ YES ☐ NO** (If YES, spare is needed for school)
- **Does your child have Asthma: ☐ Yes ☐ No** (If YES, spare inhaler is needed for the school)
- **Have your child been diagnosed with ADD/ADHD: ☐ Yes ☐ No**

If taking medication; please provide the name(s) and dosage: _____

- **Any other medical conditions that requires monitoring during school: ☐ Yes ☐ No**

If yes, please list: _____

Does your child have Health Insurance: ☐ YES ☐ NO

Name of Insurance: _____ Policy #: _____

Name of Pediatrician: _____ Phone #: (_____) _____ - _____

Emergency Contact Information:

Emergency Contact**#1**: _____ Relationship: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work #: (_____) _____ - _____

Emergency Contact**#2**: _____ Relationship: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work #: (_____) _____ - _____

Immunization Information:

Is your child up to date on ALL immunization: ☐ YES ☐ NO
(Please enclose most recent copy of immunization record. If exempt, please provide exemption letter)

When was your child's last physical: _____ (please enclose most recent copy)

Mandated Screening Programs will be done throughout the school year. Please complete the following to either decline or allow your child to participate.

Information on ALL screenings can be found on the school website at www.icslowell.com under nursing.

Vision & Hearing screening (grades PreK4, 5, and 7)

☐ Yes my child may participate
☐ No, my child will NOT participate

Postural Screening (grades 5 through 8)

☐ Yes my child may participate
☐ No, my child will NOT participate

Height and Weight/BMI screening (grades 1st, 4th, and 7th):

☐ Yes my child may participate
☐ No, my child will NOT participate

I give permission to the school nurse and staff to share specific information about my child's medical information and history for EMERGENCY purposes ONLY: **Yes** ☐ **No** ☐

_____ _____

Parent/Guardian Signature **Date**

Please write any additional comments/information that you would like the nurse know about your child:

_____

_____

_____