

EAST KNOX SCHOOLS
STUDENT EMERGENCY MEDICAL FORM

Date _____, Bus # _____, Grade _____

STUDENT NAME

Last Name: _____ First Name: _____ MI. _____ DOB: _____

Student Address: _____ City/State: _____ Zip: _____

Student Cell Phone: _____

MOTHER/GUARDIAN

Last Name: _____ First Name: _____ Suffix: _____

Phone Home: _____ Cell _____ Work _____

FATHER/GUARDIAN

Last Name: _____ First Name: _____ Suffix: _____

Phone Home: _____ Cell _____ Work _____

OTHER EMERGENCY CONTACTS: (TWO alternate WORKING/in service numbers ARE REQUIRED)

Last Name: _____ First Name: _____ Suffix: _____ Relationship: _____

Phone Home: _____ Cell _____ Work _____

Last Name: _____ First Name: _____ Suffix: _____ Relationship: _____

Phone Home: _____ Cell _____ Work _____

Last Name: _____ First Name: _____ Suffix: _____ Relationship: _____

Phone Home: _____ Cell _____ Work _____

Last Name: _____ First Name: _____ Suffix: _____ Relationship: _____

Phone Home: _____ Cell _____ Work _____

I hereby give my consent, in the event that all reasonable attempts to contact me have been unsuccessful, for: 1) the administration of any treatment deemed necessary by Doctor _____ phone number _____ or in the event that the appropriate preferred practitioner is not available, by another licensed physician or dentist and transfer of the student to the NEAREST HOSPITAL.

Preferred Dentist _____ at phone number _____.

The following information is REQUIRED:

Physical Impairments/Medical Conditions _____ Last Tetanus Shot _____

Medication being taken _____

Other pertinent facts to be alerted to _____ Allergies _____

Signature of Parent/Guardian _____ Date _____

(If refuse to consent, you must STILL complete ENTIRE form.)

Refuse to consent for Doctor and Hospital Treatment Signature _____ Date _____

EAST KNOX SCHOOLS
STUDENT HEALTH HISTORY

**Form must be completed by
an Adult and returned by
SEPTEMBER 1ST.**

Student Name: _____

Record of illness and health problems (check disease or health problem) to which the student is subject to or has had (please comment at bottom if necessary).

Chicken Pox _____	Rheumatic Fever _____	Convulsion/Seizures _____
Mononucleosis _____	Heart Disease _____	Fainting Spells _____
Diabetes _____	Asthma _____	Bladder or Kidney Problems _____
Headaches _____	Allergies _____	Paralysis or Muscle Weakness _____
Migraines _____	(Allergic to, specify:) _____	Juvenile Arthritis _____
ADHD _____	_____	Cerebral Palsy _____

	Yes	No	Please Describe
Does student have a			
Vision problem			
Hearing problem			
Speech/Language problem			
Learning problem			
Sever allergic reaction, please describe			
Is an Epi-pen or other medicine need for reaction?			
Other illness or health problems, please describe.			
Is there any tendency in your family towards a specific health problem?			
Is student taking any prescribed medication?			
What is the medication being taken for?			
Does student have any unusual reactions to injury or illness?			

Has the student had any serious injuries or operations? _____

Are there any restrictions on the student's participation in school activities? _____

Are there any restrictions regarding the administration of first aid? _____

If you want to discuss any of your child's health problems, please call the school nurse.

Additional Comments: _____

I **approve** or **disapprove** to have my child's picture published in the newsletter/annual report-calendar.

Circle appropriate

I **approve** or **disapprove** to have my child's picture published on the East Knox Website. (Child's name withheld).

Circle appropriate

Residential Parent/Guardian Signature _____ Date _____