Sussex Technical High School **School Year: _____**

Emergency Health Form

Last Name: _____ First Name: _____ Date of Birth: ___/___/_____

Choose one: Gender Grade: _____ (Upper classmen) Pathway Chosen: _____

PARENT/GUARDIAN INFORMATION	
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Address: _____	Home Address: _____
Home/Cell Phone: _____	Home/Cell Phone: _____
Place of Employment: _____	Place of Employment: _____
Work Phone: _____ Ext.: _____	Work Phone: _____ Ext.: _____

If PARENTS/GUARDIANS cannot be reached, school is to call:

1. Name (relation): _____ Phone #: _____ Phone #: _____
2. Name (relation): _____ Phone #: _____ Phone #: _____
3. Name (relation): _____ Phone #: _____ Phone #: _____

Primary Care Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Medical Insurance: _____ Policy #: _____

(The purpose of this form is to provide the school with information to be used for the care of a student who becomes sick or injured at school. This information may be shared only on a "need to know" basis with school personnel and emergency medical staff.)

SCHOOL PROCEDURES: I give permission for the school nurse to give my child non-prescription medications (acetaminophen, ibuprofen, antacids, diphenhydramine, non-Sudafed sinus tabs, etc.)

*****PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

Sussex Technical High School has adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies the school will seek immediate medical care.

In case of emergency and/or need of medical or hospital care the school will call EMS (911) for transport to the nearest medical facility:

1. The school will contact the parents/guardian utilizing all numbers available listed on this emergency card.
2. The school will call the other telephone number(s) listed.
3. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility.
4. The school will continue to call the parents or guardians until one is reached.

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for transporting and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician.

By signing this form, I acknowledge understanding the purpose of the form and attest to the accuracy of the information.

*****PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

STUDENT HEALTH HISTORY UPDATE: (This information will be shared on a need to know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise.)

Last Name: _____ First Name: _____ Date of Birth: ___/___/_____

Choose one: Gender Grade: _____ (Upper classmen) Pathway Chosen: _____

PLEASE **CHECK IF CHILD HAS HAD DIFFICULTY** WITH ANY OF THE FOLLOWING:
Give dates and additional information under comments.

1. General Health

☐ ADD/ADHD	☐ Body Piercing/Tattoo	☐ Hearing	☐ Seizures
☐ Allergies **See #2 for more details**	☐ Bone/Spine	☐ Heart	☐ Speech
	☐ Bowel/Bladder	☐ Infections	☐ Surgery
☐ Asthma	☐ Diabetes	☐ Kidney	☐ Vision
☐ Blood Disorder	☐ Emotional	☐ Physical Disability	

☐ OTHER: _____

Comments: _____

2. Does your child have allergies to medicine, food, latex, insect bites or environmental factors?
☐ **NO** ☐ **YES** To what: _____
What happens? _____
Treatment: _____
3. Has your child had any illnesses since school last ended?
☐ **NO** ☐ **YES** Type of illness, with date(s): _____
4. Has your child had surgery since school last ended?
☐ **NO** ☐ **YES** Type of surgery, with date(s): _____
5. Has your child received any immunizations since school last ended?
☐ **NO** ☐ **YES** List immunizations, with dates: _____
6. Is your child being treated or evaluated for any health conditions?
☐ **NO** ☐ **YES** List condition: _____
7. Is your child on any medication or treatment?
☐ **NO** ☐ **YES** Name of medication and/or treatment: _____
Does your child need medicine during school hours?
☐ **NO** ☐ **YES** ***If yes, please contact the school nurse to make arrangements for drop off.**
8. Has your child ever been examined by an eye doctor?
☐ **NO** ☐ **YES** Date of last exam: _____
☐ **NO** ☐ **YES** Glasses Prescribed
If your child wears glasses or contact lenses, when was the prescription last changed? _____
9. What is the date of his/her last dental exam? _____
10. What is the date of his/her last physical exam? _____
11. Indicate student's serious medical diagnoses: _____
12. Has your child experienced any major life events, such as a recent move, death, separation, divorce, etc. since the end of last school year?
☐ **NO** ☐ **YES** ***If yes, please contact your school nurse or school counselor.**
13. Have you, your child or anyone in your household tested positive for COVID-19?
☐ **NO** ☐ **YES** ***If yes, please contact the school nurse.**

*****PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____