SALTILLO PRIMARY SCHOOL STUDENT EMERGENCY NURSE FORM Grade: _____
Teacher: _____

_____ _____ _____
Student Last Name First Name Middle Name
SS# _____ Male or Female _____ DOB: _____
Mother/Guardian: _____ Father/Guardian: _____
Home Address: _____ Home Address: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Employer: _____ Employer: _____
Work Phone: _____ Work Phone: _____

List two people who will pick up your child if you cannot be reached:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Other children in the household:
Name: _____ School: _____ Grade: _____
Name: _____ School: _____ Grade: _____

Students Doctor: _____ Phone: _____
Students Dentist: _____ Phone: _____

LIST ANY MEDICATIONS TAKEN PRESENTLY (including dosage and schedule):
1.) _____ 3.) _____
2.) _____ 4.) _____

LIST ALL FOOD OR MEDICAL ALLERGIES: _____

Please indicate if your child is medically covered by the following, including the policy name and number:
Yes _____ No _____ CHIPS _____
Yes _____ No _____ Medicaid# _____
Yes _____ No _____ Hospital Insurance _____

Please check yes or no to all that apply to your child:
Yes _____ No _____ Eye Problems Comment _____
Yes _____ No _____ Wears Glasses When _____
Yes _____ No _____ Hearing Problems or Devices _____

The following medical information may be released, if necessary, to school officials who need information to protect the health or safety of students.
Check any health conditions that your child may have:

_____ ADD/ADHD	_____ Cystic Fibrosis	_____Epilepsy	_____ Asthma
_____ Diabetes	_____ Kidney Disease	_____Sickle Cell	_____ Severe Allergies
_____ Multiple Sclerosis	_____ Cerebral Palsy	_____ Muscular Dystrophy	_____ Other

Comments: _____

Parent/Guardian Signature: _____Date: _____