Washington School District Health Office
20__- 20__
Emergency Contact & Health Information

Students Name_____ Male/Female Grade____ Homeroom_____
Last First Middle Initial Circle one

Address _____Birth Date_____
Street Address Town State

Home Phone _____Cell (Mom) _____ Cell (Dad)_____

Father/Step-father_____ Work Phone_____

Mother/ Step-mother_____ Work Phone_____

Guardian_____ Work Phone_____

If none of the above can be contacted, what ***local*** person shall we call in case of accident or illness? Contact may authorize Medical treatment

Name_____ Relationship _____Phone_____ Yes or No

Name_____ Relationship _____Phone_____ Yes or No

Name_____ Relationship _____Phone_____ Yes or No

List All **Allergies**_____

List any routine/daily medications, including inhalers_____

List any medical condition or health history (Ex. Asthma, ADHD, Diabetes, Seizures or Surgeries):

_____

_____

The following medications are available from the school nurse. Please check the medication your son/daughter may receive:

Antacids/ Tums	Yes_____ No_____
Cough Drops	Yes_____ No_____

Parent Signature:_____

Students are NOT permitted to carry ANY medication, even over the counter medication with them in school. (Exception is Asthma Inhalers and Epi-Pens).

I give permission for necessary health information to be shared with this child's teachers: Yes___ No___

I attest that the above information is true to the best of my knowledge, and I will notify the school of any changes in phone numbers, address, or medical condition.

Parent/Guardian Signature_____ Date _____