BRITISH INTERNATIONAL SCHOOL OF BOSTON
A NORD ANGLIA EDUCATION SCHOOL

Student Emergency Contacts and Health History Form: 2024-2025 Academic Year

Student Contact Information

Last Name:_____First Name:_____Middle: _____

Gender: _____Date of Birth: _____Year Group: _____Teacher: _____

Home Address:

Street: _____Apt: _____

City: _____State: _____Zip: _____Home Phone: _____

Primary Contact Information

Parent/Guardian 1: _____Relationship: _____

Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email:_____

Parent/Guardian 2: _____Relationship: _____

Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Email:_____

Emergency Contact Information (*should be local and available to contact or to pick up the student in emergencies*)

Emergency Contact 1: _____Relationship: _____

Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Emergency Contact 2: _____Relationship: _____

Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Call Priority List: *Please prioritize names/numbers of contacts listed in the order you wish us to call in an emergency*:

Call 1st :_____**Call 2nd**: _____

Call 3rd:_____**Call 4th**: _____

MEDICAL INFORMATION

Primary Care Provider: _____

Practice Name: _____Phone Number: _____

Practice Address: _____

Other Health Care Providers: _____

Were there any complications at birth? ____Yes __No If yes, please explain: _____

_____

Student Allergies (list all): _____

Does Student have an Epi-Pen/Auvi-Q? ___Yes __No

Student Medications (list all): _____

_____

Student Medications to be taken at school:_____

_____

Student Health Conditions (check all that apply and provide details):

___Asthma _____

___Heart Condition_____

___Seizures _____

___Diabetes _____

___Vision Condition (glasses, contacts, other) _____

___Hearing Condition (hearing aids, etc.)_____

___Bleeding Disorder_____

___ADD/ADHD_____

___Migraines _____

___Mental Health _____

___Hospitalizations/Surgeries_____

___Other _____

_____

Please add any further information regarding physical or emotional health/needs that you feel are necessary to facilitate the health and well-being of your child at BISB:_____

_____

If your child has a life-threatening allergy (LTA), asthma, diabetes, or seizure disorder an Emergency Action/Care Plan must be completed and signed by your child's health care provider and a parent/guardian. These forms are available on the BISB website, Parent's Essentials page under Medical Forms. Forms will need to be submitted to the school nurse prior to the first day of school each school year.

Please initial next to each statement below providing consent for the following:

___I give permission for the school nurse to share information relevant to my child's health conditions with appropriate school personnel when needed to meet my child's health and safety needs.

___I give permission for the school nurse to exchange information with my child's primary care provider for the purpose of referral, diagnosis and treatment.

___All information listed above is accurate and up to date. Should anything change, I will contact the school immediately to update and/or correct details.

Parent/Guardian Signature: _____**Date**: _____