



Student Emergency Contacts and Health History Form: 2023-2024 School Year

Student Contact Information

Last Name: _____ First Name: _____ Middle: _____

Gender: _____ Date of Birth: _____ Year Group: _____ Teacher: _____

_____ Annual update: I certify there are no changes to Contact information for my child. (Proceed to page 2 – Medical info).

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

___Annual update: I certify there are no changes to my child's medical history (Proceed to page 3 – initials, signature, date).

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:** _____