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Eastern Suffolk BOCES
Educational Services That Transform Lives

2022-2023
ANNUAL HEALTH HISTORY – EMERGENCY CONSENT FORM

Student's Name:_____ Date of Birth: _____

Student's Address: _____

Home Phone: _____

Parent/Person in Parental Relation

Mother: _____ Home#: _____ Work#: _____ Cell#: _____

Father: _____ Home#: _____ Work#: _____ Cell#: _____

Emergency Contact Person

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Allergies: ☐ Yes ☐ No List: _____

Chronic Conditions: _____

Serious injuries, illnesses, surgeries or hospitalizations: _____

History of seizures: ☐ Yes ☐ No Date of last seizure: _____

History of asthma: ☐ Yes ☐ No Date of last Tetanus: _____

Glasses: ☐ Yes ☐ No Other: _____

Student is taking the following medication at home and/or in school: (List additional medications on back of this form.)

(1)_____ Dosage_____ Time(s)_____

(2)_____ Dosage_____ Time(s)_____

(3)_____ Dosage_____ Time(s)_____

I hereby give my consent to have my child, _____, examined and treated, if indicated, at the nearest Emergency Room in the event of injury or illness that may occur during school hours while he/she is a student at Eastern Suffolk BOCES.

The school nurse has permission to contact the student's physician at any time. This information may be shared with those persons involved with the care of my child.

Parent/Person in Parental Relation Signature:_____ **Date:**_____

*****Please use the white labeled envelope provided in your packet to return this form to the school nurse.***