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2021-2022
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.