Booneville Elementary School
479-675-5103
Medical Emergency Contact Form
2018-2019 School Year

Student's Name _____ Male ___ Female ___ Birthday_____ Grade _____

Address: _____

Mother's Name _____ Employer _____

Home Phone _____ Cell _____ Work _____

Father's Name _____ Employer _____

Home Phone _____ Cell _____ Work _____

Who has legal custody of your child? _____

Email for Alert Notices_____

Emergency Contacts: The following people have permission to pick up my child from school:

Name: _____ (H) _____ (W)_____ (C) _____Relationship_____

Name: _____ (H) _____ (W)_____ (C) _____Relationship_____

Name: _____ (H) _____ (W)_____ (C) _____Relationship_____

Name: _____ (H) _____ (W)_____ (C) _____Relationship_____

Health Information:

Condition	Yes	No	Description	Current Medications	Desired Action By School
Drug Allergies					
Anaphylactic Allergies requiring Epinephrine (Epi Pen)					
Diabetes					
Convulsive Disorder/Seizures					
ADHD					
Infectious Disease or Other Condition					
Other Medical Conditions					

**Please note that an Individualized Care Plan (IHP) or Action Plan may be required for your child with ongoing health needs such as those listed above. These forms will be distributed by the school nurse as needed.*

1.) Health Insurance Company: _____ Policy/Group # _____

Policy Holder's Name: _____

2.) Family Physician: _____ Phone: _____ Address: _____

3.) Family Dentist: _____ Phone: _____ Address: _____

IN THE EVENT OF A MEDICAL EMERGENCY, YOUR CHLD WILL BE TRANSPORTED BY LOCAL EMS TO THE NEAREST FACILITY, BOONEVILLE HOSPITAL, AT YOUR EXPENSE.

Students are NOT allowed to carry any medication with them – not even Tylenol! This is a law! All medication must be kept in the nurse's office and have a permission slip from the parent/guardian. If your child needs to carry an inhaler, please contact the nurse for the proper forms. In order for a student to carry an inhaler at school, these forms must be signed by a doctor.

Has your child had any of the following?

Kidney Problems	Yes	No	Age ____	Asthma	Yes	No	Age ____
Ear Infections	Yes	No	Age ____	Allergies	Yes	No	Age ____
Frequent Colds	Yes	No	Age ____	Strep Throat	Yes	No	Age ____
Heart Problems	Yes	No	Age ____	Nosebleeds	Yes	No	Age ____
High Blood Pressure	Yes	No	Age ____	Fainting	Yes	No	Age ____
Blood Disorder	Yes	No	Age ____	Seizures	Yes	No	Age ____
Stomach Problems	Yes	No	Age ____	Tubes in Ears	Yes	No	Age ____
Vision Problems	Yes	No	Age ____	Back Problems	Yes	No	Age ____

Any other problems that you want the nurse to be aware of? _____

_____

Is your child currently taking medication on a regular basis? YES NO

If yes, please list the medication and the reason your child is taking this medication:

MY CHILD MAY HAVE:

1. Non-aspirin products Yes No
2. Ibuprofen Yes No
3. Diphenhydramine (Benadryl r.) Yes No
4. Tums r. Yes No
5. Cough Drops Yes No
6. Triple Antibiotic ointment Yes No
   Which contains bacitracin, neomycinsulfate, polymyxin B sulfate.

Medical Statement: I, the undersigned, do hereby authorize officials at Booneville School District to contact directly the persons named on this form and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of this child. In the event physicians, other persons named on this form, or parents cannot be contacted, the officials are hereby authorized to take whatever action deemed necessary in their judgment for the health of the child. I will not hold the school district financially responsible for the emergency care and/or transportation of the above child.

_____ _____

Signature of Parent/Guardian Date

If any of the above information should be changed during the school year, please notify the school. Thank you!