CENTREVILLE LAYTON SCHOOL EMERGENCY AND MEDICAL INFORMATION CARD 2022-2023

This information may be shared with Centreville Layton Staff only

STUDENT NAME: (Last) ___________________________________ (First) ________________________________ (M.I)____________

DOB: __________________ **Gender:** _____________ **Age:** _____________ **Date of last physical examination:** ____________________

Family Physician: ____ **Phone:** (_________)_____________________

Child's Psychiatrist (if applicable): ____ **Phone:** (_________)_____________________

1. PLEASE CHECK IF YOUR CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS:

[ ] ADD/ADHD
[ ] Autism Spectrum Dis.
[ ] Asthma
[ ] Behavior
[ ] Bleeding
[ ] Bone/Spine
[ ] Bowel/Bladder
[ ] Chicken Pox
[ ] Dental
[ ] Diabetes
[ ] Emotional
[ ] Frequent colds
[ ] Fainting
[ ] Hearing
[ ] Heart
[ ] Headaches
[ ] Infections
[ ] Kidney
[ ] Menstruation
[ ] Physical Disabilities
[ ] Seizures
[ ] Speech
[ ] Vision
[ ] Other ____

Comments: ____

2. Does your child have any allergies? [ ] None [ ] Medication [ ] Seasonal [ ] Insects [ ] Food [ ] Latex [ ] Other

Please specify the allergy and the reaction: ____

Indicate treatment for allergies **(Attach the *Allergy/Anaphylaxis Action Plan* from the physician):** _________________________________

____

3. Have you, your child or anyone in your household tested positive for COVID-19? Yes ____ No ____

4. Has your child had any illness since school ended in June? Yes____ No ____

If yes, please explain ____

5. Has your child had any surgery since school ended in June? Yes ______ No _______

Type of surgery, with date(s) ____

6. Has your child been vaccinated against COVID-19? Yes ______ No _______

7. Please attach a copy of the updated immunization record to this form (including COVID-19).

8. List all your child's medications and treatments including name, dosage, frequency and reason: ___________________________________

____

9. Does your child wear glasses or contact lenses? Yes ____ No ____ Date of last prescription: __________Date of last exam: __________

10. Check next to the following to give permission for the school nurse or authorized school personnel to administer:

___ **All of the below**
____ **None, please call first**
___ Benadryl
___ Cough drops/throat lozenges
___ Ibuprofen (Motrin)
____ Tums
____ Eye drops (Visine/lubricating drops)
____ Oral anesthetic (Oragel)
____ Acetaminophen (Tylenol)
____ First aid antibiotic ointment (Neosporin/Bacitracin)
____ Topical (Benadryl/Clear Itch/Hydrocortisone 1%)

The Parent/Guardian(s) will be contacted for any child who is seen, evaluated and/or treated in the nurse's office. If it is not an emergency, the nurse will send an email to the email address on file. If we need to speak with you immediately, we will call the emergency numbers listed for the parent/guardian(s) until we get human voice contact.

Parent Signature ____ **Date** ___________________________