Hobbs Municipal Schools Emergency Information & Permission Form

SCHOOL:	TEACHER:	GRADE:

STUDENT INFORMATION

Student ID #:	Last Name:	First Name:	MI:
Sex: M F	Enroll Date:	Date of Birth:	
Address:			
Home Phone:	Language Spoken at Home:		

PRIMARY FAMILY CONTACTS (WHO THE SCHOOL SHOULD CALL FIRST)

Parent/guardian name:	Relationship:	Work number:	Cell number:	Lives with: Y N
Parent/guardian name:	Relationship:	Work number:	Cell number:	Lives with: Y N

EMERGENCY CONTACTS (WHO THE SCHOOL SHOULD CALL IF PARENT/GUARDIAN CANNOT BE REACHED)

Name:	Relationship:	Home Phone:	Cell:	Work:
Name:	Relationship:	Home Phone:	Cell:	Work:
Name:	Relationship:	Home Phone:	Cell:	Work:

TO GRANT CONSENT - In case of emergency involving my child and I cannot be reached, I hereby give my consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Primary Care Provider: (Physician, Nurse Practitioner or Physician Assistant)		Phone #:
Dentist:		Phone #:
Medical Insurance:	ID #:	No insurance ❑
Preferred Hospital:		

FACTS CONCERNING STUDENT'S MEDICAL HISTORY

❑ Student has no current health problems

Please indicate if the student has had or is currently under treatment for any of the following conditions:

Condition	Year/Age Problem Occurred	Condition	Year/Age Problem Occurred	Condition	Year/Age Problem Occurred
ADHD/ADD		Seizures		Meningitis	
Asthma Inhaler yes ❑ no ❑		High Blood Pressure		Migraine Headaches	
Diabetes Insulin yes ❑ no ❑		Gastrointestinal Conditions		Muscular Weakness or Paralysis	
Ear/Hearing Problems Type:		Emotional Problems Type:		Bleeding Disorders Type:	
Heart Problems Type:		Infectious Diseases Type:		Hepatitis Type:	
Vision Problems Type: Glasses: Contacts:		Cancer		Other Type:	

Student Name:	Grade:	Date of Birth:

FACTS CONCERNING STUDENT'S MEDICAL HISTORY continued…

Allergies: __Seasonal __Bee Sting __Animals __Food (list_____) __Other (list_____)

Does this student require an EpiPen for life threatening Allergies? Y N

Allergy Testing: Date: _____ Doctor's name: _____ Phone #: _____

Reactions to medicine or injections? Y N (if Y explain)

Hospitalized for serious illness, surgery, or accidents? Y N (if Y explain)

List any problems not identified above :

List current medications (prescription, herbal, over-the-counter):

Parental/Guardian Permission

- If for any reason, the above listed medical providers or hospital cannot be reached, I give permission for appropriate medical care and transport to be provided for my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless at least two licensed medical providers concur to the need. Nothing in this section shall be construed to impose liability on any school official or school employee who in good faith attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

  Signature Parent/Guardian: _____ Date: _____

- I, the undersigned as legal parent/guardian of _____ authorize the sharing of information related to my child's health between the school nurse (and designee) and the health care providers listed above. This constitutes a release of information for mutual exchange of health/medical information for educational or emergency purposes of my child for the current school year only.

  Signature Parent/Guardian: _____ Date: _____

- I give permission for my child to participate in all school health screenings according to school district policy unless I provide the school nurse and/or administration with a separate written notification requesting exclusion from specified screenings.

  Signature Parent/Guardian: _____ Date: _____

***School Nurse* NOTES:**