

**LANCASTER MENNONITE SCHOOL – LANCASTER CAMPUS
HEALTH ROOM EMERGENCY FORM**

Student Name: _____ ID# _____

Homeroom _____ Birth date _____ Male Female

Home Address _____ Home Phone _____

Mother's Name _____ Employer _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Father's Name _____ Employer _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Guardian's Name _____ Employer _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Child Lives With: Both Parents Mother Father Guardian Foster Family
(Please check one) Mother & Stepfather Father & Stepmother Other (explain) _____

Custody Information on File at School? (Please check one if separated or divorced) YES NO

LOCAL EMERGENCY CONTACTS (Other than Parents)

	<u>NAME AND RELATIONSHIP (to child)</u>	<u>PHONE</u>	<u>ALTERNATE PHONE</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Ethnicity _____ Language Spoken at Home _____

School Attended Last Year _____ Age on September 1 _____

Grade Attended Last Year _____ School District of Residence _____

Is your telephone unlisted? YES NO Is this child your youngest child in school at LMS? YES NO
Other siblings, if any, attending LMS _____

SCHOOL HEALTHROOM INFORMATION

STUDENT'S PHYSICIAN:	PHONE:
STUDENTS DENTIST:	PHONE:

I consent to the release of information from immunizations, physical and/or dental exams from my family physician's office. YES NO
Each year the school nurse prepares a confidential list that includes students who have significant health concerns. This list is shared with staff for the sole purpose of protecting the health and well being of the student. By signing below, you allow the nurse to share any information deemed appropriate.

Student name: _____ Phone: _____

Parent/Guardian signature: _____ Date: _____

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Student name: _____

SPECIAL HEALTH PROBLEM OR PHYSICAL LIMITATIONS that the School Nurse or teacher needs to be aware of.

Asthma? YES NO Is emergency inhaler needed at school? YES NO
Medication(s) (dose, time) _____

Seizure disorder? YES NO Type _____
Medication(s) (dose, time) _____ Date of last seizure _____

Diabetes? YES NO Type 1 Type 2
Medication(s) (dose, time) _____ Diet restrictions: _____

Cardiac Condition? YES NO Gym Restrictions? YES NO
Describe; _____
Medications(s) (dose, time) _____

Severe allergies? YES NO
Check: peanut tree nuts egg milk shellfish latex environ. seasonal
Other (please specify): _____
Drug Allergies (Please list): _____

Allergy Treatment Plan: (include medications, dose, and time) _____

List any other medical conditions: _____

List all of your child's medications taken at home and in school (dose, time, and reason): _____

ANNUAL HEALTH UPDATE

Serious illness, injury, hospitalization or operation during the past year? YES NO
Describe: _____

Is your child still under treatment? _____ YES NO

Restricted from physical activity? (Written restrictions signed by a doctor are required) YES NO
Describe: _____

Special diet and/or have a specific food restriction? (Milk restrictions require a doctor's note) YES NO
Describe: _____

Glasses Contacts Hearing aids Ear tubes Other _____

Hearing problem? Describe _____

Immunizations during the past year?

DPT, Td, or DT _____ Polio _____ Hepatitis B 1. _____ 2. _____ 3. _____

Tetanus _____ MMR _____ Varicella _____

Recent changes we should be aware of? (separation, divorce, illness, death, etc.) YES NO

Does your child have any emotional problems? YES NO

For confidentiality, please return this completed form to the school in a sealed envelope marked "Emergency information". Additional concerns may be listed on a separate piece of paper. By signing below, I am verifying that the above information is true and correct to the best of my knowledge.

Parent/Guardian Signature: _____

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