Returning Student

For Staff Use
Classroom: __________
Updated by:__________
Date:________________

Health and Emergency Contact Information

Child's Information

Child's Name: ___________________________________ Date of Birth: ____________________

Home Address:____

Parent/Legal Guardian #1:

Name: ____Relationship: ________________

Address (*if different from above*):____

Phone Number: ____________________________ E-mail: _______________________________

Driver License Number: ____________________ License Plate Number: __________________

Name of Employer: _________________________ Work Phone: ___________________________

Days/Hours of Employment: ____

Address of Employment: ____

Parent/Legal Guardian #2:

Name: ____Relationship: ________________

Address (*if different from above*):____

Phone Number: ____________________________ E-mail: _______________________________

Driver License Number: ____________________ License Plate Number: __________________

Name of Employer: _________________________ Work Phone: ___________________________

Days/Hours of Employment: ____

Address of Employment: ____

Emergency Information

Transport Arrangement in an Emergency Situation:

Hospital Preference: ____

**If one is not specified, Windham Hospital will be utilized. **

I give consent for trained CFDRC staff to provide my child with first aid and/or transport them via ambulance to a hospital as needed. I understand that when my child is ill or needs to be picked up for other unexpected reasons that I (or another designated adult) must arrive within thirty minutes of being called. I agree to review and update this information whenever a change occurs or every six months.

Parent/Guardian #1 Signature: ________________________ Date: ____________

Parent/Guardian #2 Signature: ________________________ Date: ____________

Emergency Contacts (to whom child may be released to if legal guardian is unavailable): ***Emergency Contacts must bring a photo ID***. If you have more than two emergency contacts attach additional sheet.

Name #1: ______________________________Relationship to child:___________

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Other: __________________________

Name #2: ______________________________Relationship to child:___________

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________________ Other: __________________________

Name of any other individuals who may access your child's CFDRC health records:

Health

Asthma: No Yes **Allergies**: No Yes **Epi-Pen Needed**: No Yes

If answered yes to any, please explain:

My Child has or has had:

- Diabetes
- Seizures
- Brain or neurologic concerns
- Head injury or concussion
- Bleeding disorder or bleeding that's very hard to stop
- Problem with under eating or weight loss
- Stomach or intestinal concerns
- Heart concerns
- Bone or joint concern
- Glasses
- Hearing Aid(s)
- Activity or gym restrictions (requires doctor's note)
- Problem with overeating or weight gain
- ADD, ADHD, Hyperactivity
- Depression
- Other psychological concern
- Frequent absences from school
- Concerns in school
- Concerns at home
- Other medical concern(s)

Please provide more information if any are checked off:

I give permission for the CFDRC nurse to contact my child's health care provider for purposes of care planning and medication administration.

I understand that all records, documentation, and discussion between the CFDRC nurse and health care providers will be confidential and I will be consulted before any changes are made in the care of my child.

Yes, CFDRC may contact my child's provider ☐

No, CFDRC may not contact my child's provider ☐

Child's Pediatrician: ______________________________ Phone Number: ________________

Address: ____

Child's Dentist: ___________________________________ Phone Number: _______________

Address: ____

Child's Health Insurance:

Is your child covered by medical insurance? No Yes

Name of Insurance Plan: ________________________________ ID #: ______________________

Subscriber's Name (on insurance card): ____