



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. **

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:

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: _____

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:

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

Please provide more information if any are checked off:

I give permission for the CFDRN 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 CFDRN 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, CFDRN may contact my child's provider

No, CFDRN 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): _____