

FOR OFFICE USE ONLY

School Year : _____
Grade: _____

EMERGENCY CONTACT INFORMATION

Parent or Guardian: In order to care for your child in the event of accident, sudden illness or other emergency, please complete all sections below and sign in the space provided. Please notify the Nurses' Office of any changes if and when they occur.

Student's Name: _____ **Preferred Name:** _____

Sex: M / F Date of Birth _____ / _____ / _____
Month Day Year

Nationality: _____

Student Resides with: _____ Both Parents _____ Mother _____ Father _____ Guardian

Mother/Guardian's Name:

Father/Guardian's Name:

Home Address: _____

Home Address: _____

Home Phone: _____

Home Phone: _____

Cell Phone: _____

Cell Phone: _____

Office: _____

Office: _____

Company Name: _____

Company Name: _____

Language(s) Spoken: _____

Language(s) Spoken: _____

For Emergency – Person(s) to call IF one of parents cannot be reached:

Primary Contact: _____

Secondary Contact: _____

Phone: _____

Phone: _____

Cell Phone: _____

Cell Phone: _____

Local Doctor or Health Care Provider _____

Phone: _____

If student will be staying with a guardian, please provide contact information for the parents:

Phone number _____

E-mail _____

Health Conditions: (check all that apply):

_____ Ear/Hearing Problems _____ Epilepsy _____ Emotional Problems _____ Asthma
_____ Eye/Vision Problems _____ Migraines _____ Heart Problems _____ Diabetes
_____ ADD/ADHD (attention deficit / hyperactivity) _____ Other (specify) _____

Special Medical Considerations: _____

Medication and Food Allergies: _____

Current Medications: _____

IMMUNIZATION HISTORY

Students are expected to meet the AIS/D Immunization and Tuberculosis Screening requirements upon entry or at the beginning of the school year. However, when a series of immunizations are required, such as for polio, your child will be provisionally permitted to attend school after the initial dose. AIS/D follows the Center for Disease Control Immunization Schedules. This may be different from your home country or country you are moving from.

Parent or Guardian: Please write in the dates of the required immunizations and TB screen in the table below. Use MONTH/DAY/YEAR format.

Polio

1.	2.	3.	4.
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Diphtheria/Pertussis/Tetanus (DPT)

1.	2.	3.	4.	5.
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Mumps/Measles/Tetanus (MMR) (Measles alone not acceptable)

1.	2.
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Chickenpox

1.	2.	If child had Chickenpox put date here:
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Haemophilus influenza, type B (Hib) (Required only if student less than five years old)

1.	2.	3.	4.
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TB Screening (Required every two years) If your child has had a BCG a physical exam is acceptable, otherwise a skin test or Chest X-Ray is required.

BCG date:	CXR:	Physical:	Skin Test:
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NOTE: You will be informed if and when your child is due for further immunizations and when another TB screen is due.

In cases of emergency or sudden illness requiring immediate care your child will be taken to the nearest appropriate hospital and you will be notified as soon as possible.

Signature and Authorization:

I certify that all the information provided above is accurate and true. Please check one of the following:

_____ School nurse/doctor may administer acetaminophen, ibuprofen, naproxen, chloraseptic throat spray, antihistamine and/or bismuth subsalicylate

_____ Notify me before my child is given medication

Date: _____ Signature of Parent/Guardian: _____