Emergency Action Form
2018-2019

THIS SHEET MUST BE SIGNED AND RETURNED AT REGISTRATION. If your child is a new student to our district, please complete all information on the lines provided on this page and the **Student Health Inventory on the back of this form.**

Student's Name: _____
Home Address: _____
City, State, Zip: _____
Date of Birth: _____
Gender: *(Please circle)* Female Male
Grade: _____
Medicaid #:*(opt.)* _____

GUARDIAN INFORMATION:

Legal Guardian 1: _____
Main Phone: _____
2nd Phone: *(opt.)* _____
Employer: _____
Employer Phone: _____
Relationship to student: _____
Address - (*If different than the address listed above*).
Address: _____
City/State/Zip: _____

Legal Guardian 2: _____
Main Phone: _____
2nd Phone: *(opt.)* _____
Employer: _____
Employer Phone: _____
Relationship to student: _____
Address - (*If different than the address listed above*).
Address: _____
City/State/Zip: _____

In this section, please list the relationship of the individual(s) that the student lives with.
(Ex. Mother, Father, Step Mother, Step Father, Sibling, Grandmother, Grandfather, Foster Parent, Relative, or Other)

The student **lives with** _____ and *(if applicable)* _____.

PLEASE NOTE: This section is used for two types of information. Please list the Non-custodial Parent in this section or in cases of Joint Custody, please fill in the second household information in this section.

Non-Custodial Parent or Joint Custody: _____
Address: _____
City: _____
Phone: _____
Relationship to student: _____

Preferred SchoolMessenger Number(s):
SchoolMessenger is the district's calling service for announcing important information via voice and text messages. Place a phone number on the lines below if you would like to be called or texted by this service.
SchoolMessenger Voice #1: _____
SchoolMessenger Voice #2: _____
SchoolMessenger Text #1: _____
SchoolMessenger Text #2: _____

EMERGENCY CONTACT INFORMATION: Please list individual(s) to call in case of emergency if the Guardian(s) listed in the box(es) on the left cannot be reached. Enter **only one** phone number per emergency contact.

Name: _____
Relationship: _____
Phone: _____

Name: _____
Relationship: _____
Phone: _____

Name: _____
Relationship: _____
Phone: _____

EMERGENCY PROCEDURES
If you cannot be reached in an emergency, and if in the judgement of school personnel, immediate and/or hospital attention is indicated, do you authorize responsible personnel to send your child (properly escorted) to an available hospital or physician?
(Please circle one) **YES** **NO**

****PLEASE NOTE: IN CASE OF A LIFE THREATENING EMERGENCY, AN AMBULANCE WILL BE CALLED.****

If No, please list procedures for School Personnel to follow in case of a non-life treating emergency:
_____
_____
_____

_____
Signature of Legal Guardian **Date**

BETHALTO SCHOOL HEALTH SERVICES
Student Health Inventory

Your child's learning depends upon good health. To assist us in providing health services at school, please complete the following form and return to your school nurse. **This information may be shared with staff as appropriate for the well being of your child.**

Name:_____ DOB: ____/____/____ Gender: Male Female
Last First Middle

Physician's Name:_____ Physician's Phone:_____ Date of last physical: _____

Dentist's Name: _____ Dentist's Phone: _____ Date of last exam: _____

Is your child under orthodontist's care? YES NO Orthodontist's Name:_____

Allergies to drugs, food, insects, pollen ? YES NO Please list: _____
Has the allergy required emergency action this past year? YES NO Comments:_____
Please circle: Mild Moderate Severe

Does your child have difficulty breathing? YES NO Comments:_____
Does your child need emergency medication? YES NO Type of medicine: _____

Does your child have asthma? YES NO
Asthma triggered by: _____ Treatment: _____
Asthma Action Plan submitted to the school? YES NO

Does your child have Diabetes? YES NO Date diagnosed: _____
Does your child take Insulin? YES NO

Does your child have epilepsy/seizures? YES NO Describe seizure: _____
Is your child under doctor's care for seizures? YES NO Date of last seizure:_____
Medication:_____

Does your child have a Heart Condition? YES NO Describe: _____
Does your child have Physical restrictions? YES NO Medication:_____

Does your child have bone or joint problems? YES NO Describe: _____
Any physical restrictions?: _____

Circle any of the following health concerns that pertain to your child:

Eyes:	Glasses/Contacts:	Reading / Distance	Difficulty Seeing	Crossed	Lazy Eye
Ears:	Tubes	Frequent Infections	Hearing Difficulty	Hearing Aid: Left Right	Wears aid at school
Other:	Nosebleeds	Eating	Sleeping	Bladder	Menstruation
	Lungs	Neurologic	Headaches	Bowels	Blood Disorder
	Phobias	ADD/ADHD	Dental	Bedwetting	Blood Pressure
	Skin Conditions	Requires Diapering	Requires Catheterization		

Daily medication at home? YES NO Name of medication and reason for taking:_____
_____
_____

Daily medication at school? YES NO Name of medication and reason for taking:_____
_____

Please Note: If your child requires medication at school, either prescribed as needed or over-the-counter, a medication form must be on file in the nurses office or if a change in physical education participation is required, please send the appropriate note from your physician.

List serious illness or injuries:_____
Surgeries (operations):_____
Condition that prevents PE participation:_____

Other health information concerns:_____
"Information pertinent to any communicable disease outbreak/diagnosis may be shared with the appropriate agency(s)"

If you would like information regarding State Health Insurance, offered by the State of Illinois, please contact your child's school nurse or www.allkids.com

_____
Signature of Parent/Guardian Date