HIGHLAND PARK INDEPENDENT SCHOOL DISTRICT

HEALTH AND EMERGENCY INFORMATION FORM **School Year** _____

STUDENT NAME _____, _____ _____ _____
Last **First** **Middle** **Preferred Name (nickname)**

Gender: F / M **Birthdate:** ____/____/____ **Grade:** _____ **School:** _____ _____
(circle one) **TEACHER**

Custodial Parent/LEGAL Guardian with whom student has Primary Residence:

HIS Name: _____ **Relationship:**_____ HM (____)_____

_____WK (____)_____ C (____)_____
Address (Street, City, ST, Zip)

HER Name: _____ **Relationship:**_____ HM (____)_____

_____WK (____)_____ C (____)_____
Address (Street, City, ST, Zip)

Name(s) of Co-Custodial or Non-Custodial Parent(s), (if applicable):

HIS Name: _____ **Relationship:**_____ HM (____)_____

_____WK (____)_____ C (____)_____
Address (Street, City, ST, Zip)

HER Name: _____ **Relationship:**_____ HM (____)_____

_____WK (____)_____ C (____)_____
Address (Street, City, ST, Zip)

May the student be released to the non-custodial parent listed above (if applicable)? YES / NO (circle ONE)

SIBLINGS (please list name and school): _____

Alternate Adult Contacts: In case of emergency, I hereby authorize HPISD to allow my child to leave school only with the parent or legal guardian(s) listed above or the following persons:

_____ 1. (____)_____ 2. (____)_____ 3. (____)_____
Name Relationship Contact Phone #'s

_____ 1. (____)_____ 2. (____)_____ 3. (____)_____
Name Relationship Contact Phone #'s

Doctor Name:_____ **Phone:**_____ **Dentist Name:** _____**Phone:**_____

Hospital Preference:_____

Does your student have an allergy to any of the following? ❑ **Food(s)**_____ ❑ **Insect(s)** _____

❑ **Medication(s)**_____ ❑ **Latex , or** ❑ **Other**_____

Please check if allergy is: ❑**Severe** ❑**Moderate** ❑ **Mild**

The medication(s) used to treat the allergy: ❑**Benadryl** ❑ **Epinephrine** ❑ **Other**_____

Has your child had a severe "anaphylactic" reaction requiring emergency care in the: ❑ **Past Year?** ❑ **2 Yrs.?** ❑ **5 Yrs.?**

❑ **Student receives services from Special Education**

Please inform us of the specific areas to address with your student:

❑Allergies-seasonal	❑ Eating Disorder	❑ Muscular/Orthopedic Disorder
❑ADHD	❑ Epilepsy/Seizure Disorder	❑ Psychosocial
❑ Asthma	❑ Heart Condition	❑ Serious Accident
❑ Chicken Pox - Date:_____	❑ Hearing Problems	❑ Surgery
❑ Cystic Fibrosis	❑ Kidney Disorder	❑ Vision Problems
❑ Diabetes	❑ Migraine Headache	❑ Other: _____

If you would like to add to any of the above concerns:

_____

If your student is on medication, please list medication, dosage, frequency and reason for medication:

_____

Please note any concerns of which the school nurse needs to be aware: _____

_____

*****Please contact your school nurse within first month of school if your child has a serious allergy or condition*****

❑**Yes** ❑**No** I give the school nurse permission to contact my student's physician or dentist in a medical necessity.

❑**Yes** ❑**No** I give the school nurse permission to share my students relevant medical information with appropriate school personnel for educational and safety reasons.. Your campus school nurse is available for any concerns.

Signature of Parent or Guardian: _____ **Date:** _____

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