

Student Name Last _____ First _____ MI _____	Birthdate _____	Teacher/Grade _____	Student ID # _____	Medicaid # _____
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Round Rock Independent School District
HEALTH SERVICES HEALTH INFORMATION AND EMERGENCY FORM

HEALTH INFORMATION

Dear Parent/Guardian
 The information requested on this form is needed to maintain a school health record for your child.
Please understand that this information may be shared with school personnel who have a need to know.

STUDENT DISEASE HISTORY

	YES	NO
Diabetes	_____	_____
Asthma	_____	_____
Heart Disease/Disorder	_____	_____
High Blood Pressure	_____	_____
Kidney Disorder	_____	_____
Curvature of Spine	_____	_____
Blood Disorder	_____	_____
Hearing Loss	_____	_____
Vision Loss	_____	_____

If you marked any of the above "Yes", please explain _____

During the past year, has your child developed any medical condition requiring continuing medical care? (i.e. diabetes, leukemia, seizures, etc.) _____

During the past year has your child been hospitalized? If yes, please explain _____

Is your child on any kind of medication? If so, what? _____

To be taken at school? **YES NO** (Circle one) **if yes, see nurse for medication form.**

Please Note: The school nurse or any other school personnel may not give any medication without written permission from a parent or legal guardian. Any daily medication which needs to be given for longer than one month requires written permission from a physician.

All medication must be in the original container with a proper label. Also, prescription medication must contain the physician's name, child's name, a current date, current dosage, and directions for use. The child's medication plan must be such that the medication cannot be sufficiently administered outside of school hours.

EMERGENCY INFORMATION

In case of ACCIDENT OR SUDDEN ILLNESS, we need the following emergency information.
Please do not block school number.

Mother's or Female Guardian's Name _____

Home Address _____ Apt. _____ City _____ Zip _____

Phone: Home _____ Cell _____ Pager _____

Business Phone _____ Ext. _____

E-Mail address _____

Father's or Male Guardian's Name _____

Home Address _____ Apt. _____ City _____ Zip _____

Phone: Home _____ Cell _____ Pager _____

Business Phone _____ Ext. _____

E-Mail address _____

Child Lives with Both Father Mother Other

Who is authorized to pick up child _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.
 Name _____ Phone _____
 Name _____ Phone _____

List the after school care your child attends:
 Name _____ Phone _____

DOCTOR _____ PHONE _____

I, the undersigned, do hereby authorize officials of Round Rock Independent School District to contact directly the persons named on this form, and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of the child.

In the event physicians name on this form, or parents cannot be contacted, I understand that school officials will take whatever action deemed necessary in their judgement for the health of said child.

I hereby grant my authorization and consent to medical care, treatment, procedure, or physician consultations deemed necessary in order to ensure the health of said child.

I will not hold the school district financially responsible for emergency care or transportation of said child.

Student's Last Name _____ First _____ Signature of Parent or Guardian _____
 Relationship to Student _____ Date _____

My child has CHIP Medical Insurance Medicaid No Insurance