

**STUDENT EMERGENCY RECORD
SOUTH TEXAS I.S.D.**

Grade: _____ ID#: _____

School Year: _____

DOB: _____

Entry Date: _____

Last Name of Student

First Name

Middle Name

Address

City

Zip Code

Home Phone

Emergency Phone

Name

Relationship

Name of Father

Occupation

Business Phone

Cell Phone

Name of Mother

Occupation

Business Phone

Cell Phone

Family Physician

Choice of Hospital

EMERGENCY MEDICAL AUTHORIZATION

I hereby authorize District employees to administer prescription, as well as nonprescription medication, when PROVIDED by me under the following provisions.

1. The District has received a written request to administer the medication from the parent, legal guardian or other person having legal control of the student.

2. When administering the medication, the medication must be in the original container and be properly labeled.

3. Medication obtained outside of the United States shall not be administered by district employees to students unless written authorization is on file from a physician licensed to practice in the United States.

I give authorization for the school to call the family physician and to follow the recommendations of the physician. I give authorization for an ambulance to be called, if necessary. I give authorization for another doctor to treat my child in case the family physician is not available. I give authorization for my child to be given the necessary medical attention in case the school cannot communicate with me. **I will not hold the school district financially responsible for the emergency care and/or transportation of my child.**

Parent/Guardian Signature

Date

List any medication your child is taking:

At home _____

At school _____

All medication should be brought to the clinic on arrival to school. Medication should be brought to the clinic by the parent. Parents will complete proper forms when medication is dropped off

Please Turn Over





Student Name: _____

DOB: _____ Grade: _____ ID#: _____

School Year: _____

Has your child had any of the health problems listed below? Please explain if you answer yes.

Condition:	Yes	No	Elaboration:
Allergy- Seasonal, Environmental, Food, medication.			to what?
***"Severe food allergy means a dangerous or life-threatening reaction of the human body to a food-borne allergen introduced by inhalation, ingestion, or skin contact that requires immediate medication attention. <u>If it is not listed, there will be an understanding that your child does not have any allergies.</u> ***			
<u>Life threatening allergies/reactions?</u>			to what? Require medication?
Asthma – A doctor's written authorization is required to carry and self-administer asthma medication at school.			Has a doctor given approval for your child to carry and self-administer the medication in school?
Mental/Psychological Disorders			If yes, what disorder? Require medication?
Birth defect			
Diabetes			
Chronic Ear Infection			Has tubes?
Hearing Problems			Hearing Aids?
Eye - Wears glasses or contacts?			
Other Disorders of the Eye			
Epilepsy/Seizures			Date of last seizure?
Hepatitis			Type: A B C
Kidney/Bladder Problems			
Rheumatic Fever			
Ulcers/Gastritis			
Orthopedic/Bone Problems?			
Heart Problems			
Doctor ordered restrictions?			

Other Conditions or Comments: _____