EMERGENCY MEDICAL INFORMATION

Student Name _____ DOB _____

Allergies _____

Parent/Guardian Name _____ Mobile # _____

In the event the parent/guardian cannot be reached, who should we contact in an emergency?

Contact # 1 _____ Mobile # _____ Relationship _____

Contact # 2 _____ Mobile # _____ Relationship _____

Contact # 3 _____ Mobile # _____ Relationship _____

Physician Name _____ Phone _____

Current Medications (Dose/Frequency) _____

_____ Blood Type _____

Previous Surgery _____

Medical History/ Health Issues (Circle all that apply)

Asthma	Sickle Cell	Migraines	Kidney Disorder	Heart Disease	Cancer
Diabetes	Seizures	Hepatitis	Bronchitis	Blood Disorder	Other _____

I, the parent/guardian of the above named child, hereby authorize the named Healthcare Provider who has attended to my child, furnish to the School Nursing Supervisor and/or School Nursing Staff any medical information and/or copies of records pertaining to my child's medical history and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPPA) disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance at NHND Preparatory Academy. This authorization expires as of the last day of the school year.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

AUTHORIZATION TO TRANSPORT

I hereby authorize NHND personnel to take my child to the hospital emergency room for treatment. I understand that I am legally responsible for any financial obligations incurred for the treatment of my child.

Parent/Guardian _____