

Dickenson County School Health Services Emergency & Illness Information

School Year: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Bus #: \_\_\_\_\_

Parent Name/Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Homerom Teacher: \_\_\_\_\_

**Person to Contact if Parent(s) is not available**

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Full Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Please list any medical problems, severe allergies, etc. which would require immediate medication or medical attention:

\_\_\_\_\_  
\_\_\_\_\_

Bee sting allergy that requires epi-pen: Yes      No      Seizures: Yes      No

Asthma that requires inhaler at school: Yes      No

Food/Peanut allergy that requires epi-pen: Yes      No

List food allergies: \_\_\_\_\_

Medication to be given at school: Yes      No

If yes, please list medication: \_\_\_\_\_

List of medications your child takes at home: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

**Please check if you give permission for:**

Cold/allergy medication  
Mylanta/Tums  
Cough drops  
Tylenol/Acetaminophen  
Ibuprofen/Motrin

If your child begins taking Tylenol/Ibuprofen repeatedly, it is at the discretion of the nurse as to whether to give medications to your child or not.

**First Aid** includes applying Neosporin, Calamine lotion (anti-itch cream), band aids, wound wash, eye wash, and etc. If you do not want any of these products used on your child, please list them below:

\_\_\_\_\_

I \_\_\_\_\_ give permission for the school staff to share my child's health information with other school staff, Health Dept., MD, or other related health personnel, in the event that my child's health is at risk. (Example but not limited to: immunization info, diabetes, allergies to foods/bee's, communicable outbreaks, 911 situations and medication/nursing treatment at school).

If emergency treatment is required, and the parents or guardian cannot be reached immediately, your signature in the space provided below empowers school authorities to exercise their judgement in calling the physician indicated above, or if not available, to transport child to a hospital emergency room.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Special Note:** Please notify school officials immediately as to any changes or modifications to any information stated above.

Email forms to:

Donna Mooney [dmooney@dcps.k12.va.us](mailto:dmooney@dcps.k12.va.us)

Lilly Thacker [lthacker@dcps.k12.va.us](mailto:lthacker@dcps.k12.va.us)

Audrey Rasnake [arasnake@dcps.k12.va.us](mailto:arasnake@dcps.k12.va.us)

Thank you so much for taking the time to fill out these forms.  
We greatly appreciate your cooperation.