Hartland/Lakeside School District
Health and Emergency Form
Summer Splash

STUDENT'S LEGAL NAME: ______________________________ Grade ____________

Last First M.I. Date of Birth ____________

Address: ______________________________ Home Phone ____________

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EMERGENCY CONTACTS

	Name & Relationship -- Please Prioritize Order of Notification	Daytime Phone Number	Cell Phone Number
1	Parent/ Guardian:		
2	Parent/ Guardian:		
3	Other:		
4	Other:		

Local Physician: ______________________________ Phone ____________

Dentist: ______________________________ Phone ____________

In an emergency, transport my child to Waukesha/ Aurora/ Oconomowoc Summit Memorial Hospital

CURRENT MEDICAL CONDITIONS:

CIRCLE conditions if applicable

	YES	NO		YES	NO
Neurological disorder/ Seizures			Skin Conditions		
Traumatic Brain Injury/ Spinal Cord Injury/ Stroke			Endocrine/ Thyroid Problems		
Frequent Headaches / Migraines			Growth Problems		
Sleep Problems			Diabetes		
Frequent Ear Infections			Blood disorder/ anemia/ bleeding		
Ear/Hearing Problem			Immune Disorder		
Eye/Vision Problems Glasses yes/no			Allergies to Medications		
Frequent Sinusitis/ Nosebleeds			Allergies (environmental or seasonal)		
Dental problems			Congenital/ Genetic Conditions		
Asthma / Respiratory Problems			Chronic Illness		
Heart Problems, surgery, or murmurs			Cancer (past or current), tumors		
Urinary/ Bladder / Kidney Problems			ADD/ADHD		
Stomach/ Digestive problems			Anxiety/Depression/OCD/Bipolar		
Chronic Constipation / Bowel Problems			Autism/ PDD		
Obesity or Eating Disorder			Behavioral Problems		
Muscle/ Bone/ Joint Problems			Developmental Delay		

List any condition in more detail and/or list medical conditions not mentioned above:

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SEVERE LIFE-THREATENING ALLERGIES: *Describe reaction*

____ Bee Stings, other insects: ______________________________

____ Tree Nuts, Peanuts: ______________________________

____ Other Food Products: ______________________________

____ Other Severe Allergies: ______________________________

Has your physician prescribed an Epi-Pen or other medicine for a severe life-threatening allergy?

[ ] Yes[ ] No Specify medication:______________________________

Please complete the Allergy Action Plan and the Authorization to Administer Medication Form, available in the school health office or online under the Health Room tab.

DATES OF LAST:

Physical Exam: ______________________

Dental Exam: ______________________

Professional Eye Exam: ______________________

Please list any surgery or hospitalizations in the last year:

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MEDICATION: List <u>all</u> medication that your child is taking on a regular basis:

Medication Name	Amount	Time of Day *	Reason for Use

If medication is taken at school, please complete the Authorization to Administer Medication Form, available in the school health office or online under the Health Room tab

I hereby authorize:

1. Release of above information to all pertinent Hartland/Lakeside School District personnel, coaching staff and school bus drivers.
2. If the school is unable to reach me, school personnel may call the physician indicated on the reverse side and follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements deemed necessary.
3. Permission for transporting my child for emergency care.

Signature of Parent/Guardian: ______________________________ Date: ____________

Signature of Parent/Guardian: ______________________________ Date: ____________

Both parents must sign if parents live apart and have joint custody.