LEBANON PUBLIC SCHOOLS

Lyman Memorial High School 917 Exeter Rd., Lebanon CT. 06249
School Nurse: Phone (860) 642-7673 Fax: (860) 642-3570

PLEASE RETURN FORM BY 8/10/2022

STUDENT EMERGENCY INFORMATION 2022-2023

Student Name: _____Grade (2022-2023): _____
Last First
Student Address: _____
Street Town Zipcode
Home Phone: _____ BIRTHDATE (M/D/Y): ____/____/____

PARENT/GUARDIAN INFORMATION

Parent Name: _____ Home Phone: _____
Address:_____ Cell Phone: _____
Email Address:_____ Wk. Phone:_____
Employer: _____ Occupation: _____

Parent Name: _____ Home Phone: _____
Address:_____ Cell Phone: _____
Email Address:_____ Wk. Phone:_____
Employer: _____ Occupation: _____

Step-Parent/Guardian: _____ Home Phone: _____
Address:_____ Cell Phone: _____
Email Address:_____ Wk. Phone:_____
Employer: _____ Occupation: _____

EMERGENCY CONTACTS *List two (2) neighbors or relatives who will assume temporary care of your child if you cannot be reached. (They must drive and be at least18 years old.)*

1. Name/Town: _____ Relationship_____ Phone: (___)_____
2. Name/Town: _____ Relationship_____ Phone: (___)_____

Does your child have health insurance **Yes / No** If not, would you like information involving the Connecticut Husky Plan? **Yes / No**

AUTHORIZATION FOR FIRST AID, MEDICAL TREATMENT, TYLENOL / ADVIL OR OTHER MEDICATIONS

In case of accident, illness or injury, I grant permission for school personnel to administer first aid or secure medical treatment for my child. In case of emergency, your child will be taken to the nearest medical facility.

Parent/Guardian Signature: _____Date_____

I grant permission for Tylenol, Advil, Tums (or their generic forms) to be administered to my child.

Parent/Guardian Signature: _____Date_____

If your child has a life threatening allergy or a serious medical condition that may require emergency care or special procedures at school, please telephone school nurse directly prior to beginning of the school year, at time student enrolls, or as soon as diagnosis is made so plans for care can be developed.

Student Allergies	**Chronic Illnesses or Medical Conditions (list)**	**Medications (list) Include medications taken at home**
Has student been prescribed epinephrine (EpiPen, Auvi-Q, Twinject) for a life threatening allergy? Y___ N___ If yes, list allergy:_____ Other Allergies:_____	_____ _____ _____	_____ _____ _____

Please turn over and fill out reverse side

LEBANON PUBLIC SCHOOLS
ANNUAL HEALTH SUMMARY
School Year 2022-2023

Student Name: _____ Grade:_____

Student's Physician: _____ Phone:(___)_____

Please check the following illnesses or conditions that apply:

( ) Frequent colds
( ) Sore throats
( ) Ear Infections/hearing impairment
( ) Seizure disorder
( ) Heart
( ) Kidney
( ) Diabetes
( ) Migraines / frequent headaches
( ) Other _____
( ) Asthma

If checked, please rate asthma severity level

( ) mild intermittent ( ) mild persistent
( ) exercise induced ( ) severe persistent

( ) Bone Fractures
( ) Dislocations/Sprains
( ) Scoliosis
( ) Weight Problems
( ) Recent Surgery/hospitalization
( ) Concussion/Head injuries
( ) Frequent nosebleeds
( ) High blood pressure
( ) Skin conditions

Allergic to:

( ) Animals
( ) Drugs
( ) Foods_____
( ) Milk, Milk products
( ) Bee stings
( ) Environmental allergies (dust, pollen, grass, etc)
( ) Other Allergies

Epinephrine prescribed? (Y____ N___) If yes, list allergy_____

Please explain any conditions checked above:

_____

_____

Is there any other condition pertaining to your child's health you would like to bring to the attention of the school nurse? (Please include any major health changes in last year.)

_____

_____

- Has your child had a tetanus booster in the past year? Y_____N_____ If yes, date_____
- Does your child wear glasses or contacts? Y_____N_____ for Distance____ Reading___

Will your child need to take medication at school. Y_____ N_____ List med._____

Connecticut State Law requires a written medication order signed by an authorized prescriber and parent/guardian be submitted for any medication administered at school or any medication authorized to be self-carried by student (inhalers & Epinephrine by older students). Contact school nurse for more information or if forms are needed.

I have reviewed the above information and completed it to the best of my knowledge.

Parent/Guardian Signature_____ Date_____