School Year _____

Teacher/Grade_____/____

Student Emergency Care and Health Form

Bullard Independent School District

Student: _____, _____, _____ _____ ____/____/____
Last Name First Middle Age DOB

_____ _____
Address City/Zip Code

Call 1st	**Call 2nd**
Parent/Guardian:	Parent/Guardian:
Cell#:	Cell#:
Home#:	Home#:
Work#:	Work#:
Place of Employment:	Place of Employment:

Other people who are authorized to pick up or transport my child if I am unable to be located:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Health Information

Check and Complete all that apply to your child.

ALLERGIES- Life-Threatening Allergy

____Food (list foods) - _____
____Insect sting (list insects) - _____
____Medication (list medications) - _____
____Other (list) - _____

Circle Reaction: cough hives rash local swelling wheezing difficulty breathing nausea

generalized swelling other_____

Does your child have emergency medications prescribed for treating the allergy? ____No___Yes (**Contact School Nurse**)

++Oral antihistamine (Benadryl, etc.) +Epi-pen +Other _____

__PARENT/GUARDIAN MUST SUPPLY ALL MEDICATIONS__

Parent/Guardian must provide BISD Student Nutrition office with a note from the doctor for any special dietary considerations regarding school lunches.

(COMPLETE BACK SIDE OF FORM→**)**

_____ **ASTHMA** – (**If You Checked Contact School Nurse**)
_____exercise induced asthma _____occasional attacks _____severe attacks
Does student need an inhaler at school _____No ____Yes (**Contact School Nurse**)

_____ **DIABETES** – (**Contact School Nurse**)

_____ **SEIZURE DISORDER** – (**Contact School Nurse**)

_____ **OTHER HEALTH CONDITIONS** – **circle** all that apply
Arthritis Bladder Blood Disorder Cancer Cerebral Palsy Cystic Fibrosis Digestive Disorder
Eating Disorder Fainting Heart Condition Kidney Disorder Migraine/Headaches Nosebleeds
Sickle Cell Disease Skin Disorder Stomach Other:_____

Please explain medical conditions not listed or

_____
_____
_____
_____

____ **VISION** Contacts Glasses Blind

____ **HEARING** If checked, does student wear Hearing Aids _____Yes _____No

Medication your child is currently taking:

Name	Dose	Reason
Name	Dose	Reason
Name	Dose	Reason

Will your child be taking any routine medication at school _____No _____Yes (See School Nurse)

Bullard ISD **does not** provide over the counter medications such as Ibuprofen, Tylenol, Cream, Cough Drops, etc. **If you want your child to have medications at school the parent must bring them to the nurse's clinic in the original, properly labeled container, and complete permission forms.**

All/any of the above information may be provided to Bullard ISD staff in order to keep each student's health and safety a top priority. This information will only be given to those teachers, coaches, and staff directly involved with the student and staff members are informed that all student information is confidential.

Hospital:_____ **Physician:**_____

I, the undersigned, do hereby authorize officials of **Bullard Independent School District** to contact directly the persons named above, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the said child.
In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.
I will not hold the school district financially responsible for the emergency care and/or transportation of said child.

Parent/Guardian: ____ **Date:**_________________________