Connecticut Technical High School System--Health History & Emergency Contact Form

Student Name_____ _____Grade _____ Shop_____ Date of Birth_____ Male ☐ Female☐

Lives with: ☐ Both Parents ☐Mother ☐Father ☐Legal Guardian: _____ ☐ Other: _____

Home Address: _____ Town_____ Zip Code_____

Emergency Contact Information: Names & grades of siblings attending this School: _____

Mother/Guardian's name: _____ Home Phone: _____

Address: _____ Town: _____ Zip: _____ Cell Phone: _____

Name of Employer_____ Work Phone: _____

Mother/Guardian's Email Address: _____

Father/Guardian's name: _____ Home Phone: _____

Address: _____ Town: _____ Zip: _____ Cell Phone: _____

Name of Employer_____ Work Phone: _____

Father/Guardian's Email Address: _____

If parent or guardian cannot be reached call:
1) Name: _____ Home #_____ Cell # _____ Work #_____ Relationship_____
2) Name: _____ Home #_____ Cell # _____ Work #_____ Relationship_____
3) Name: _____ Home #_____ Cell # _____ Work #_____ Relationship_____

Family Doctor's Name: _____ Phone #_____
Family Dentist's Name: _____ Phone #_____
Hospital Preference*: _____
*In the event of an emergency we will notify emergency personnel of your hospital preference. We cannot guarantee transport to a specific hospital.

Parent/Legal Guardian Signature: _____ Date: _____ **(Other Side Must Be Completed)**

Student's name: _____ Date of Birth_____ Shop _____

Is your child covered by Medical Insurance? ☐Yes ☐ No
Medications taken at Home **(daily or as needed):** _____

Medications taken at School: _____

Allergies **(food, medication, insects, latex, other):** ☐ No ☐ Yes _____ EpiPen needed? ☐ No ☐ Yes

Asthma ☐no ☐ yes If yes, ☐ mild ☐ moderate ☐ severe ☐ exercise induced? Inhaler needed: ☐ Yes ☐ No

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☐ I, _____ (Parent/Guardian name) give the school nurse permission to speak with my child's doctor about allergy and/or asthma management. Parent/Guardian Initials: _____ Date: _____

My child has or has had:_ ☐ Diabetes ☐ Seizures ☐ Brain or neurologic problem ☐ Head injury or concussion ☐ Bleeding disorder or bleeding that's very hard to stop ☐ Stomach or intestinal problems ☐ Heart problems ☐ Bone or joint problems ☐Glasses ☐ Contacts ☐Hearing Aid(s) ☐ Activity or gym restrictions (**requires doctor's note)** ☐ Problem with overeating or weight gain ☐ Problem with under-eating or weight loss ☐ ADD, ADHD or hyperactivity ☐ Depression ☐ Other psychological problem ☐ Frequent absences from school ☐ Problems in school ☐ Problems at home ☐ Other medical problem (s)_____
Please provide more information for any box checked above: _____

_____

_____

Parent/Legal Guardian Signature: _____ Date: _____

(Other Side Must Be Completed)

For School Nurse's Use Only: