GM GENERAL MCLANE SCHOOL DISTRICT **STUDENT INFORMATION FORM**

Student Name: ______________________________ Grade: __________
Address: ______________________________
City: ______________________________ Zip Code: __________
Birthdate: __________ Homeroom: __________ HR Teacher: __________

PARENT/GUARDIAN INFORMATION					
Please complete the information below using parents as the first two contacts. Include two other contacts you would like to be called in case of an emergency and a parent/guardian is unable to be reached.					
Parent/Guardian 1:				Relationship:	
Home Phone:		Cell Phone:		Work Phone:	
Place of Work:			Active Military:	Yes☐	No☐
Email Address:					
Parent/Guardian 2:				Relationship:	
Home Phone:		Cell Phone:		Work Phone:	
Place of Work:			Active Military:	Yes☐	No☐
Email Address:					

OTHER CONTACT INFORMATION					
Other Contact 1:				Relationship:	
Home Phone:		Cell Phone:		Work Phone:	
Place of Work:				Work Hours:	
Other Contact 2:				Relationship:	
Home Phone:		Cell Phone:		Work Phone:	
Place of Work:				Work Hours:	

If mailings for this child should be sent to another address, please indicate below:					
Name:				Relationship:	
Address:		City/State:		Zip:	

HEALTH INFORMATION	Family Physician:		Phone:	
I give permission for the school to dispense:	**Acetaminophen** Yes ☐ No ☐		**Antacid** Yes ☐ No ☐	
List any current health problems which are under treatment. Provide dates of recent immunization booster:				
Emergencies/Allergies:				
Any medication needed for emergencies/allergies must be provided by the parent, including Bendaryl and EpiPens for bee sting/allergic reactions.				
In the event I cannot be contacted using the listed information, I grant permission to the receiving health care facility to administer appropriate care to my child: Yes ☐ No ☐				

Is there a court order on file that would restrict release of this student? If YES, a recent copy must be attached.
Yes ☐ No ☐

Authorized Signature of Custodial Parent/Guardian: ______________________________

Date: ______________________________

ALERT NOW PHONE PREFERENCE FOR AUTOMATED CONTACT SYSTEM (Please complete all entries.)					
Primary Phone:		Emergency 2 Phone:		Emergency 3 Phone:	

Check all information listed. IF ANYTHING HAS CHANGED, PLEASE NOTE. Be certain to provide appropriate information on any blank line. Form must be signed by parent/guardian.

Dear Parents/Guardians,

General McLane School District is committed to protecting the well being of our students. To enable us to do the most for the health of our students, it is imperative that we be aware of your child's current health condition and treatments.

Please complete this questionnaire. Feel free to call if there are any areas you would like to discuss further or special instructions of which you would like us to be aware.

Remember, any medication that may need to be administered in case of an emergency must be supplied by you. The only medication provided by the school is acetaminophen (Tylenol), ibuprofen (Motrin) and antacid (Maalox). **Please see your school nurse for the form that needs to be completed to administer medication at school.**

List any health problems below, as well as any special consideration or treatment that may be required during school hours. In addition, please remember during the school year to notify us of any change in health status or treatments, change or addition to medications, and any other information that may be pertinent to the well being of your child.

Thank you for helping us to keep your child safe and healthy.

Sincerely,

The General McLane School Nurses

PLEASE PROVIDE INFORMATION OF WHICH YOU WANT YOUR CHILD'S TEACHER TO BE AWARE.

UPDATE TO HEALTH HISTORY			
Does your child have asthma?	☐ Yes ☐ No	Does he/she carry an inhaler?	☐ Yes ☐ No
Are there any allergies?	☐ Yes ☐ No	Epi Pen?	☐ Yes ☐ No
Please list:			
Does your child have seizures?	☐ Yes ☐ No	On Medication?	☐ Yes ☐ No
Is your child on daily medication?	☐ Yes ☐ No	**(If yes, please complete information below.)**	
Name of medication(s):			
Time taken:			
Reason:			
Please provide dates of any immunization booster in the past year (please attach physician copy):			
Immunization:		Date Administered:	
Immunization:		Date Administered:	
Are there any special medical or emotional concerns?	☐ Yes ☐ No		
If yes, please explain:			
Is your child under treatment for medical or emotional reasons?	☐ Yes ☐ No		
If yes, please explain:			

PLEASE COMMUNICATE WITH THE SCHOOL NURSE ANY INFORMATION YOU WANT KEPT CONFIDENTIAL.

_______________________________ **Parent/Guardian Signature**

_______________________________ **Date**