PARIS INDEPENDENT SCHOOLS
STUDENT HEALTH INFORMATION/EMERGENCY TREATMENT RELEASE FORM

Date_____ School _____ Grade_____

Student _____ □ Male □ Female DOB_____ Home Phone (_____) _____
Last First Middle

Physician's Name _____Office #_____Dentist_____Office#_____

Health Insurance Company _____Name of Policy Holder _____ Policy #_____

Preferred Hospital _____ Phone_____

Preferred Ambulance Service, of other than EMS _____ Phone_____

Please check any health condition(s) or substance that causes our child to have a severe allergic reaction requiring immediate emergency treatment:

EARS	□ YES	□ NO
Hearing difficulties	□ YES	□ NO
Hearing aids	□ YES	□ NO
Chronic infections	□ YES	□ NO
EYES	□ YES	□ NO
Glasses	□ YES	□ NO
Contacts	□ YES	□ NO
HEART	□ YES	□ NO
Fainting spells	□ YES	□ NO
Chest pains	□ YES	□ NO
History of Heart Disease	□ YES	□ NO
LUNGS		
Tuberculosis	□ YES	□ NO
SPINE/NECK	□ YES	□ NO
BACK	□ YES	□ NO
Scoliosis	□ YES	□ NO
SHOULDERS	□ YES	□ NO
ARM- elbow, wrist, hand	□ YES	□ NO
LEG- hips, knees, ankles, feet	□ YES	□ NO
KIDNEYS	□ YES	□ NO
BOWELS	□ YES	□ NO

SKIN	□ YES	□ NO	
SPECIAL NEEDS	□Auditory	□Visual	□Speech
ALLERGIES			
Asthma	□ YES	□ NO	
Food	□ YES	□ NO	Be Specific _____
Drug	□ YES	□ NO	Be Specific _____
Insect bites	□ YES	□ NO	Be Specific _____
Peanuts	□ YES	□ NO	Be Specific _____
Other – please be specific _____			

ARTHRITIS	□ YES	□ NO
CHICKEN POX	□ YES	□ NO
DIABETES	□ YES	□ NO
HEMOPHILIA	□ YES	□ NO
MIGRAINES	□ YES	□ NO
NOSE BLEEDS	□ YES	□ NO
SEIZURES	□ YES	□ NO
BLOOD TYPE	_____	
OTHER CONDITION (Please be specific) _____		

If your child is under a physician's case for a chronic condition, please explain thoroughly.

_____

List the medications your child takes on a regular basis and explain the reason for each (Note: if your child is required to take medication during school hours, you must complete an additional authorization form located in the front offices)

_____ _____
_____ _____
_____ _____

Is there a reason your child cannot participate in all vigorous Physical Education activities? □ YES □ NO If "yes" please explain why. _____
_____

I, _____, the lawful parent/guardian of _____ do hereby authorize the agents and employees of the Paris City Board of Education to procure such emergency medical treatment as may reasonable necessary to provide or the health and well-being of said minor child at an time that such minor is in the custody of said board of Education either while in attendance at school or while enroute to or from school, or school activity.

I further authorize the same agents or employees of the said Board of Education to sign any and all consents required by physicians or hospital in connection with said emergency treatment, as are considered necessary or desirable in the judgment of the attending physician or hospital authorities.

In connection herewith, the Board of Education agrees that it will direct its agents and employees to make a prudent attempt to contact the parent or guardian of the child prior to emergency medical care or treatment being administered.

_____ _____

Signature of Parent/Guardian Date Signed

My child does NOT have any medical conditions. If a medical condition develops, I will inform Paris Independent Schools in writing within 10 business days of medical diagnoses.

_____ _____

Signature of Parent/Guardian Date Signed

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