CHAUTAUQUA LAKE CENTRAL SCHOOL

Return this form to the Health Office

STUDENT EMERGENCY HEALTH RECORD

Please fill out **both sides** of this form and return to the school in the attached confidential envelope. To serve your child in case of a sudden illness, accident or school emergency evacuation, it is necessary that you furnish the following information.

Student's Name_____ _____ _____

Last First Middle

Address_____ __Zip_____

Mailing Address_____Zip_____

Home Phone #: _____Teacher_____Grade_____

Mother: _____ Cell Phone #:_____Work Phone #:_____

Father: _____Cell Phone #:_____Work Phone #:_____

Who has legal custody of this child? _____

Describe any custody arrangements: _____

LIST TWO NEARBY RELATIVES OR NEIGHBORS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED(Be sure to inform person listed.)

Name_____Name_____

Address_____Address_____

Phone_____Phone_____

Relationship to child _____Relationship to child_____

Child's Doctor _____Health Insurance Provider_____

List all allergies: _____

List all medications taken at home and/or at school: _____

_____

Other medical information (be specific): _____

_____

In the event physicians, other persons named on this document, or parents cannot be contacted, the school officials are authorized to take whatever actions are deemed necessary in their judgments, for the health of the aforesaid child.

I agree to provide and give permission for the use of FDA approved sunscreen on my child for avoiding overexposure to the sun. Check box if you **DO NOT** want sunscreen used. ☐

_____ _____ _____

Signature of Parent Date

CHAUTAUQUA LAKE CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your healthcare provider will require the *Release of Information Form* below to share Protected Medical Information with the school district. Please sign and return this form to the school nurse promptly to avoid delays.

_____ _____
Student's Name Date of Birth

I, _____ authorize my child's healthcare provider(s) listed below to release my
Parent's/Guardian's Name
child's medical records to **Chautauqua Lake Central School District's** medical director, physical therapist (PT),occupational therapist (OT), speech therapist (ST), school psychologist, school social worker, and/or school nurse.

HealthCare Providers:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

The healthcare provider may disclose the following protected health information (check all that apply)

____ Health History

____ Physical Examination Report

____ Immunization Records

____ Past/current medical conditions and its impact on attendance, school programming and/or PT,OT, ST, Psych testing needs.

____ Other (specify)_____

_____.

Information received on your child will be used for one or more of the following:

1. To facilitate evaluation of your child's individual educational program.
2. To determine health needs of your child which may require special services during school.
3. To facilitate health counseling or school health services which you may wish for your child.
4. To provide school district personnel with a better understanding of your child's health needs.
5. At patient's request with no specific purpose.
6. Other: _____

This authorization may be revoked by you at any time in writing and automatically expires on June 30th at the end of the school fiscal year.

I understand that my child's treatment is not dependent on my agreement to release or withhold information

_____ _____ _____
Date Signature of Parent/Guardian Relationship to child