Pansophia Academy
EMERGENCY/HEALTH FORM
To be completed annually and returned to child's school

STUDENT INFORMATION:

Last Name ______ First Name ______ Middle Name ______

HOME INFORMATION:

Home Phone: ______ **Robo Call #1**: ______ **Robo Call #2:** ______ Grade ______

Student's Address: ______
(include house number, street name, apt. or lot number, city, state, and zip code)

Names of other children in household (include name, grade, and school they are attending)

______ Grade ______ ______
______ Grade ______ ______
______ Grade ______ ______

This questionnaire is intended to address the McKinney-Vento Act:

*Presently where is the student living? ____ in a Shelter ____ with more than one family ____ Motel/car or campsite ___waiting foster care ____with friends or family members (other than parent/guardian) ____Parent/Guardian

PARENT INFORMATION:

Child lives with:
- ❒ mother & father
- ❒ mother only
- ❒ father only
- ❒ mother/step-father
- ❒ father/step-mother
- ❒ court guardian
- ❒ other (specify) ______

Mother's Name: ______ Address: ______

Mother's Employer: ______ Work phone #: ______ Cell phone #: ______

Father's Name: ______ Address: ______

Father's Employer: ______ Work phone #: ______ Cell phone #: ______

EMERGENCY CONTACT INFORMATION:

Individuals named here will be contacted on behalf of your child in the event of a medical or otherwise determined emergency if we are unable to contact the parent/guardian. List in order to be contacted. Your student will only be released to a parent or contact listed below. If you would like to list additional contacts, please attach a second sheet with the information requested below.

Contact #1: ______ Relationship to student: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

Contact #2: ______ Relationship to student: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

Contact #3: ______ Relationship to student: ______

Home Phone: ______ Work Phone: ______ Cell Phone: ______

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HEALTH INFORMATION

WAIVER FOR MEDICAL EXCLUSION: I, ______________________ , parent/guardian of ____________________________________ , Choose not to disclose all accurate health information pertaining to my child. I understand that I am responsible for any health issues that may arise due to undisclosed information, and I release Pansophia Academy and its employees from all liability.

Parent Signature: ____ Date: ______________________

ALLERGY/MEDICAL ALERT

Please check all conditions that apply to your student - **be specific. Conditions with an asterisk (*) require a specific physician action plan on file at the school - please check with school office personnel for the forms.**

- ❐ **Rx Medication**
  - ❐ depressant
  - ❐ stimulant
  - ❐ ADD/ADHD
- ❐ **Allergy (list below)**
  - ❐ epi-pen
  - ❐ reaction (explain below)
- ❐ **Asthma**
  - ❐ inhaler
  - ❐ nebulizer
  - How often ____________
- ❐ **Blood disorder/condition**
  - ❐ hemophilia
  - ❐ anemia
- ❐ **Bone disorder**
- ❐ **Bowel disorder/condition**
- ❐ ***Cardiac (heart) condition**
  - ❐ physical restrictions
- ❐ ***Diabetic**
  - ❐ injections
  - ❐ pump
  - ❐ oral/diet regulated
- ❐ ***Epilepsy**
  - Type ________________
  - How often ____________
- ❐ **Headaches**
  - ❐ migraines
- ❐ **Head injury**
- ❐ **Hearing disorder**
  - ❐ hearing loss
  - ❐ tubes
- ❐ **Low blood sugar**
- ❐ **Lung disorder**
  - ❐ pneumonia
  - ❐ bronchitis
- ❐ **Muscle disorder**
  - ❐ muscular dystrophy
- ❐ **Nerve disorder**
  - ❐ cerebral palsy
- ❐ **Nosebleeds**
- ❐ **Oral Problems**
  - ❐ partial plate
- ❐ **Other (list below)**
  - ❐ shunt
  - ❐ prosthesis
- ❐ **Scoliosis**
- ❐ **Skin condition**
  - ❐ eczema
  - ❐ dermatitis
  - ❐ impetigo
- ❐ **Stomach condition**
  - ❐ ulcer
- ❐ **Urinary problems**
  - ❐ frequent UTI's
  - ❐ incontinence
- ❐ **Vision problems**

Please give any specific instructions for care in any medical emergency concerning your child (example: who to call first, when to transport to ER, steps to follow). Please list allergies and specific information concerning medical conditions listed above. __________________________

Special Services

Support Services:

____504 Plan _____Speech Therapy ____Occupational Therapy ____Physical Therapy ____ Social Work Other: ________________

Special Education: ____Specific Learning Disability ____Emotional Impairment ____Autism Spectrum Disorder Other: ____________

Date of last IEP: ____________ Date of Last REED: ___________

I affirm that all the information provided is complete and accurate to the best of my knowledge:

Parent/Guardian Signature: ______________________________________ Date: ___________________