BRUNSWICK CENTRAL SCHOOLS

BRITTONKILL

HEALTH INFORMATION

Please be sure to fill out completely:

STUDENT INFORMATION:
Student's
Name____Birthdate_________________Grade___________________

(Step) Mother's Name_______________________________(Step) Father's Name___________________________________

Address____Home Phone_______________________

IMMUNIZATIONS:

It is required by law that student's immunization record must be supplied to the school on or before the first day of attendance. If you do not have records with you upon registration, please make arrangements with your child's doctor or previous school to either send or fax them to us. Our fax number is 279-1918, to the attention of the Health Office.

MEDICAL HISTORY:

Medicine above student is currently taking:

DRUG	MILLIGRAMS	REASON FOR TAKING MEDICATION

Please check all that apply:

____Allergies (Please explain)____

Medicines allergic to:____

Is student allergic to insect stings? YES NO (circle one)

If YES to above question: What medicine should be taken for the sting ____

Please give time allowed before medicine must be given____

Note: If possible, please see that the nurse has at least one of these pills in case an outside activity is scheduled.

____Frequent absenteeism (Please explain)____

____Frequent colds/sore throats ____Ear conditions ____Chicken Pox

____Frequent headaches ____Asthma ____Pneumonia

____Epilepsy ____Diabetes ____Heart Disease

____Rheumatic Fever

____Has had Tuberculosis or contact with infected person

____Family History of color blindness? Who?____

____Serious injuries/or illness (Please explain)____

____Operations (Please explain) ____

____Other (Please explain)____

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EMERGENCY INFORMATION:

Father's place of employment____ Wk. Phone Number__________

Mother's place of employment____ Wk. Phone Number__________

Attempt will be made to contact parent(s) in case of emergency. If not able to contact a parent, who should be contacted?

____

Name Address Home Ph. Work Ph.

____

Physician's Name Phone

Should transportation be necessary, what hospital would you want your child to be taken to:____

(Please read carefully)

In the event of any sudden illness or injury while involved in a school related activity, I give my permission for emergency treatment to be given by personnel who hold valid and up-dated first aid cards, and if necessary transportation to a hospital where the medical staff may also treat my child.

It is understood that I will be immediately contacted in the event of any emergency, but that treatment and transportation can be started in the interim. Should it be impossible to reach me I agree that treatment and transportation begin as stated.

Date_____________________________ Parent or Guardian____

I have received and read the Health Office letter which includes the HIPPA information.

Parent Authorization for Release of Medical Information

We, (I), the undersigned, who are the parent/guardian of

____ ____________________________

Name Date of Birth

give authorization to ____

Physician's Name

for release of medical information (for the duration of the child's school career) pertaining to, but not limited to, physicals, immunizations records, gym notes and medication permits to:

Brunswick (Brittonkill) Central School District
3992 NY 2
Troy, NY 12180

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Parent/Guardian Signature