

HEALTH AND EMERGENCY INFORMATION

A. **STUDENT NAME:** _____ Date of Birth: _____
(M) (D) (Y)
Living with (if other than parent(s)): _____ Grade Level _____

Family Physician: _____ Office Phone: _____

Hospital of Preference: () Hospital de Liberia () Hospital de Nicoya () Clínica Los Ángeles

B. **HEALTH INFORMATION**

Allergy () YES () NO

Medicines / Food / Insects: _____

Life Threatening Allergies: _____

C. **STUDENT'S MEDICAL HISTORY:**

- | | |
|---------------------------|--------------------------------------|
| () Asthma | () Thyroid |
| () Migraines / Headaches | () Cholitis or chronic stomach pain |
| () Diabetes | () Behavior Disorder (ADD, ADHD) |
| () Heart problem | () High blood pressure |
| () Seizures | () Other medical problems |

Comment (any items checked): _____

D. **MEDICATION**

Medicine taken at home every day: _____

Medicine taken at school every day: _____

If your child experiences fever and/or pain while at school, please indicate if the school is authorized to administer mild medication:

() YES () NO If yes, check the type below:

() Tylenol / Panadol () Ibuprofen / Dorival () PeptoBismol / Tums

() Panadol Cold () Otosedan Ear Drops () Other: _____

E. **EMERGENCY CONTACTS:** Please provide us with the names of two persons whom we should contact in your absence:

Contact 1

Contact 2

Name: _____

Relation: _____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____
