ACCEPT
Education Collaborative

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STUDENT INFORMATION – 2016-2017

Student's Legal Name:_____ Date of Birth:_____
Address:_____ Home Phone:_____

_____

Gender: M F

Parent/Guardian Information (Enter Names of legal parents, stepparents or guardians only):
***Multiple contact numbers required in the event of an emergency.**
Name:_____
Mailing Address (if different from Student):_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____
Relationship: □ Mother □ Father □ Stepmother □ Stepfather □ Other: _____

Name: _____
Mailing Address (if different from Student):_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____
Relationship: □ Mother □ Father □ Stepmother □ Stepfather □ Other: _____

*REQUIRED: If your child becomes sick at school, he/she must be picked up and taken home. Please list emergency contacts, OTHER THAN YOURSELF, should you be unavailable, that have permission to receive students in case of emergency:
1) Name: _____ Relationship:_____ Phone:_____
2) Name: _____ Relationship:_____ Phone:_____

If over 18 years of age, student has (check one):
□ Sole Guardianship □ Shared Decision-Making □ Family Guardianship
(If student has sole guardianship or shared decision-making, they are able to sign off on the enclosed forms.)

Is there a custody or restraining order in place?: □ No □Yes (If "Yes", attach copy)
Student resides with: □ Mother □ Father □ Both □ Other: _____

Health Information
Student's PCP (name & phone):_____
Medical Specialist(s)/Clinic(s):_____

_____
Student's dentist (name & phone):_____
List all current diagnoses:_____

_____
Does the student have health insurance? □ No □Yes
Insurance provider:_____ Policy ID#:_____
Do you need information about state health insurance? □ No □Yes
Does the student have dental insurance? □ No □Yes

Student's Legal Name:_____ Date of Birth:_____

Insurance provider:_____Policy ID#:_____

Current Medications – please indicate if medications are to be taken at home or school:

Medication	Dosage	Times Given		Reason For Medication
		Home	School	
1.				
2.				
3.				
4.				
5.				

Does the student have asthma? □ No □Yes
*If yes, please include their Asthma Action Plan from their provider
*If yes, do they utilize: Inhaler: □ Yes □ No Nebulizer: □ Yes □ No

Allergies
Has the student been diagnosed with a severe, life threatening allergy? □ No □Yes
* If yes, ACCEPT requires a written Doctor's order and an Allergy Action Plan
Allergist's Name: _____Phone Number: _____

Has the student ever required the use of an EpiPen to treat their allergies? □ No □Yes (please note most recent date): _____

Life Threatening Allergic Conditions (please check all that apply):
□ Bee/ Insect Stings
□ Peanuts/Tree Nuts (list nuts): _____
□ Latex
□ Other food products: (list foods): _____
□ Medications (list medications): _____

Other Allergies (non-life threatening, i.e. food, medication, seasonal):

_____

Does your child have any of the following? If YES, please explain:

Yes ___ No___ Assistive Mobility Aids (i.e. wheelchair, walker, braces):_____

Yes ___ No___ Behavioral Problems_____

Yes ___ No___ Developmental Problems_____

Yes ___ No___ Bladder/Bowel Problems_____

Yes ___ No___ Bleeding Problems_____

Yes ___ No___ Cerebral Palsy_____

Yes ___ No___ Diabetes_____ Insulin dependent □ Yes □ No

Student's Legal Name:_____ Date of Birth:_____

Yes ___ No___ Feeding Tube_____

Yes ___ No___ Head or Spinal Injury_____

Yes ___ No___ History of concussions_____

Yes ___ No___ Hearing Loss_____ Hearing Aid □ Yes □ No

Yes ___ No___ Heart Problems_____

Yes ___ No___ Recurring Illness_____

Yes ___ No___ Seizure Disorder/Epilepsy _____ Type _____ Date of last seizure_____

Yes ___ No___ Speech Problems_____

Yes ___ No___ Surgeries (what and year)_____

Yes ___ No___ Swallowing Difficulties _____

Yes ___ No___ Vision Problems_____ Glasses □ Yes □ No

Other:_____

- I will notify the ACCEPT Education Collaborative if there are any changes to the above information.
- I give my permission, in a medical emergency, for the school nurse to contact my child's doctor and/or transport my child by ambulance to a hospital for treatment. Hospital preference _____
- **I give my permission to all medical providers to release health information to the ACCEPT Nurse Leader.**

Signature of Parent or Guardian_____**Date**_____