

# G.C.I.S.D. Health and Emergency Information - 2005-2006

Grade \_\_\_\_\_ ID# \_\_\_\_\_ Teacher \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Birthdate \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street Apt # City Zip

### Custodial Parent/Legal Guardian with whom the student has Primary Residence:

Name	Relationship	Work number	Cell Number	E-mail
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### Name(s) of Co-Custodial or Non-Custodial Parent(s):

Name	Relationship	Work number	Cell Number	E-mail
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

### EMERGENCY CONTACTS (OTHER THAN ABOVE) Please use local contacts only.

1. \_\_\_\_\_  
Name Relationship Day time number Work number Cell #

2. \_\_\_\_\_  
Name Relationship Day time number Work number Cell #

Please list names, campus and grades of siblings attending other GCISD schools: \_\_\_\_\_

## PLEASE COMPLETE AND SIGN BACK OF CARD

Physician \_\_\_\_\_ Dentist \_\_\_\_\_  
Name Phone # Name Phone #

Hospital Preference: \_\_\_\_\_

Allergies to foods, medications, insects, latex or other substances?  yes  no If yes, please list allergens: \_\_\_\_\_

Please indicate if allergy is  SEVERE  Moderate  Mild Please list symptoms: \_\_\_\_\_

What medication(s) or treatment are used to treat the allergy? \_\_\_\_\_

Has your child ever had a severe "anaphylactic" reaction requiring emergency care? If so, list date: \_\_\_\_\_

### HEALTH CONDITIONS (check those that apply)

<input type="checkbox"/> Allergies-Seasonal	<input type="checkbox"/> ADD or ADHD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bone Disease/Fractures
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ear Infections (numerous)	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Epilepsy/Seizure Disorder
<input type="checkbox"/> Frequent Headaches/ Migraines	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Neuro-Muscular Disease
<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Pervasive Developmental Disorder	<input type="checkbox"/> Psychiatric/ Psychological Disorder	
<input type="checkbox"/> Special Dietary Regimen	<input type="checkbox"/> Vision Problems/glasses/contacts	<input type="checkbox"/> Other: _____	

If yes to any of the above, please explain: \_\_\_\_\_

Please list any medications that your child takes on a routine or frequent basis (include prescription and over the counter medications) \_\_\_\_\_

Are there other factors in the family that might affect your child's school experience? \_\_\_\_\_

Yes  No I give the school nurse permission to contact my child's physician or dentist should it become medically necessary.

Yes  No I give the school nurse permission to share my child's relevant medical information with appropriate school personnel for educational and safety reasons.

I authorize school personnel to obtain emergency medical care for my child in the event I can not be reached.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_