Brazosport Independent School District
Health Services ★ Empowering Our Future

Brazosport ISD Medical Emergency Form

Student's Legal Name: _____ School Year: _____
Last First Middle

Date of Birth _____ Sex: M _____ F _____ Grade: _____
Month / Day / Year

_____ _____
Street Address City Zip Mailing Address City Zip

Student's Physician's Name: _____ Address: _____ Phone: _____

The student lives with: (circle one) Father Mother Both Guardian Other (please specify) _____

_____ _____ _____ _____
Mother's Name Mother's Home Phone Mother's Work Phone Mother's Cell Phone

_____ _____ _____ _____
Father's Name Father's Home Phone Father's Work Phone Father's Cell Phone

LIST TWO NEIGHBORS OR <u>NEARBY</u> RELATIVES WHO WILL ASSUME TEMPORARY CARE OF THE STUDENT IF YOU CANNOT BE REACHED.

1. _____ _____ _____ _____ _____
Name Relationship to Student Home Phone Work Phone Cell Phone

2. _____ _____ _____ _____ _____
Name Relationship to Student Home Phone Work Phone Cell Phone

Does the student have/had any of the following conditions? <u>If yes, please explain.</u>

Yes No Asthma (Name of Inhaler) _____
Yes No Allergies: Respiratory _____ Medication _____ Food _____ Other _____
Yes No Carries an Epipen for allergic reaction to _____
Yes No Chickenpox: If yes, when? Month _____ Year _____
Yes No Diabetes _____
Yes No Hearing Impairment/Tubes _____
Yes No Heart Condition _____
Yes No ADD/ADHD (Name of Medication) _____
Yes No Stomach/Colon Disorder _____
Yes No Kidney Disorder _____
Yes No Orthopedic Impairment _____
Yes No History of **<u>severe</u>** allergic reaction to insect bites that requires medication or emergency care _____
Yes No Seizure Disorder/Epilepsy (Name of Medication) _____
Yes No Migraine Headaches (Name of Medication) _____
Yes No Visual Impairment - Wears glasses or contacts (circle one) _____
Yes No Takes prescribed medication daily at home (Name of medication) _____
Yes No Needs to take daily medication at school (Name of medication) _____
Yes No Restricted activities due to physical or medical condition _____
Yes No Other Disability/Health Problem _____

<u>Students MUST have a current Doctor note on file in order to carry epi-pens, asthma inhalers and diabetic supplies.</u>

***** NOTE: <u>All medications</u> MUST 1. Be transported to and from school by parent or guardian. 2. Have a parent/guardian permission note to be given at school. 3. Be in the original bottle/container.**

IN THE EVENT OF AN EMERGENCY, I HEREBY AUTHORIZE B.I.S.D OFFICIALS TO SECURE MEDICAL TREATMENT. I UNDERSTAND THE STUDENT IS GENERALLY TRANSPORTED BY AMBULANCE TO THE NEAREST EMERGENCY CARE FACILITY. I WILL NOT HOLD THE SCHOOL DISTRICT OR ITS EMPLOYEES FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND / OR TRANSPORTATION FOR SAID STUDENT.

_____ _____
Parent/Guardian Signature *(REQUIRED)* **Date**