2025-2026 California Area School District

CONFIDENTIAL EMERGENCY HEALTH INFORMATION

Student's Name: _____ Birthdate: _____ Sex: M/F

School: _____ Grade: _____ Teacher: _____

PARENTS: If your child has a life threatening medical condition, it is vital that you discuss this with their school nurse and teachers immediately.

A. Medical History: Indicate below any that apply to your child. If needed, provide further explanation or description under the comment section. **Proof of diagnosis is required by your child's healthcare provider.**

- ☐ Anxiety/Panic Attacks
- ☐ Arthritis/Rheumatic Disease
- ☐ Asthma - Inhaler Required: Yes ____ No ___
- ☐ Attention Deficit Disorder (ADD)
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Autism (ASD)
- ☐ Bleeding Disorder & Cooley's Anemia
- ☐ Bowel/Bladder Problem
- ☐ Cardiovascular Condition
- ☐ Cerebral Palsy
- ☐ Concussion - Date: _____ Cleared: Y ___ N ___
- ☐ Cystic Fibrosis
- ☐ Diabetes Type 1 ____ Type 2 ____
- ☐ Eating Disorder
- ☐ Epilepsy or Other Seizure Disorder
- ☐ Headaches/Migraines
- ☐ Hearing Problem
- ☐ Heart Condition
- ☐ Life Threatening Allergies (Complete Section D)
- ☐ Muscle Disorder
- ☐ Neurological Concern
- ☐ Orthopedic Problem
- ☐ Physical Activity Limitations _____
- ☐ Scoliosis
- ☐ Sickle Cell Anemia
- ☐ Spina Bifida
- ☐ Tourette's Syndrome
- ☐ Vision Problem - Contacts ____ Glasses ____ Color Blindness ____
- ☐ Other _____

Comments:

_____

_____

(Continues on Back)

B. List any other operations, injuries, hospitalizations, etc and provide the dates:

_____

_____

_____

C. History of mental health, emotional or behavioral problems (explain):

_____

_____

D. LIFE THREATENING ALLERGIES: Medications used to treat life threatening allergies **must** be provided to the school nurse by the parent/guardian along with a Medication Administration Consent.

Cause of the allergy: _____ Treatment: _____

Cause of the allergy: _____ Treatment: _____

E. Current Medications: Include ALL prescription, over-the-counter, vitamins, and herbal medications taken at home and in school.

	Name of Medication	Used to Treat	Taken at School?
1.	_____	_____	Yes ___ No ___
2.	_____	_____	Yes ___ No ___
3.	_____	_____	Yes ___ No ___
4.	_____	_____	Yes ___ No ___
5.	_____	_____	Yes ___ No ___

Before any medication can be administered at school, a medication administration form must be completed by physician and parent/guardian. A new medication form is required every school year.

In order to provide a safe and healthy environment for your child, the information provided on this form will be accessible to the following people: School Nurse, your child' s teacher, office staff, personnel responsible for health room coverage and emergency medical personnel.

If you have any question or concerns or questions about your child's health while at school, please contact:
Mrs. Lynnette Kurutz RN, CSN
E-mail: kurutzl@calsd.org
Phone: 724-785-5800 x1205 (MS/HS) or x2205 (ES)
Fax: 724-785-8860 (MS/HS) or 724-785-5458 (ES)

Parent/Guardian's Printed Name:_____

Parent/Guardian's Signature _____

Date: _____