Hartford High School/HACTC Health Services Office

STUDENT EMERGENCY INFORMATION: 2026/2027 School Year

STUDENT: Last Name_____ First Name_____ D.O.B_____ Grade _____

Home Phone:_____

Parent/Guardian Name:_____ Cell/Work Phone:_____

Parent/Guardian Name:_____ Cell/Work Phone:_____

Parent/Guardian Email:_____ Ok to send information via email? Yes No

Make sure all contact information is current in Infinite Campus. You will need to update that system separately

Please list two nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached.

1. Name _____ Home Phone_____ Work/Cell Phone _____

2. Name _____ Home Phone_____ Work/Cell Phone _____

Student's health problems (i.e. illness, disability, etc.): _____

_____

Allergies: _____

Medication taken by the student on a regular basis (continue on the back of this form if needed):

Drug name: _____ Dosage: _____ Frequency: _____

Drug name: _____ Dosage: _____ Frequency: _____

Has a doctor or healthcare professional EVER said that your child has asthma? Yes___ No____ Don't know/Not sure____

If yes, does your child STILL have asthma? Yes___ No___ Don't know/Not sure___

Child's doctor: _____Telephone: _____ Date of last physical exam: _____

Child's dentist: _____Telephone: _____Date of last routine visit: _____

Do you have health insurance? Yes ____ No ____ If yes, name of insurance carrier _____

Do you have dental insurance? Yes ____ No ____ If yes, name of insurance carrier _____

In case of a significant accident or illness, the school will attempt to contact the parent/guardian. School personnel will seek emergency medical care, including transportation to the emergency room if necessary. The school district cannot be held liable for any medical expenses incurred.

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I understand that the school nurse may occasionally need to contact my child's PCP/dentist/optometrist/specialist regarding immunizations, medications, vision or other significant health issues. I grant permission for my child's healthcare provider and the school nurse to exchange educationally pertinent medical information which they deem to be in the best interest of my child.

****Parent/Guardian Signature**: _____ Date: _____****

I authorize the school nurse to give my child: Acetaminophen (Tylenol) Ibuprofen (Advil) Antacid (Tums) for minor aches/pains

****Parent/Guardian Signature**: _____ Date: _____****

Please note students are NOT allowed to carry prescription or over-the-counter medications on their persons (with the exception of certain rescue medications). All medications must be kept in the nurse's office in the original pharmacy/manufacturer labeled container.