Berrien Regional Education Service Agency

□ **Blossomland Learning Center**
□ **Lighthouse Education Center**
□ **Math/Science Center**

HEALTH SERVICES

Date____________________________

Student=s Name________________________________ Date of Birth _______________ Room #/Grade:_____________
Father=s or Guardian=s Name____________________________________ Mother=s or Guardian=s Name____________________________________

Home Address ________________________________ City ______________________ Phone No. _________________

Father Cell Phone #______________________________ Mother Cell Phone # __________________________________

Parent email address ____________________________ Student email address ________________________________

PLACE OF EMPLOYMENT:

Father/Guardian Company _______________________ Working Hours ________ Business Phone _________________

Mother/Guardian Company _______________________ Working Hours ________ Business Phone _________________

NAME OF LOCAL PERSON TO CONTACT IF PARENT(S) ARE NOT AVAILABLE. (*THIS MUST BE COMPLETED*)

Name__________________________________ Relationship _____________________ Phone_____________________

HEALTH INFORMATION

✓ **Diagnosis:** ____

Allergies: ____

LIST ALL MEDICATIONS YOUR CHILD IS TAKING:

MEDICATION	DOSAGE	TIME GIVEN

NOTE: PLEASE CALL THE SCHOOL NURSE WHENEVER ANY OF YOUR CHILD=S MEDICATION OR DOSAGE IS CHANGED SO THAT WE CAN UPDATE OUR RECORDS.

PHYSICIAN INFORMATION

Family Doctor ____ Office phone _____________________
Address ____
Doctor (Specialist) ____ Office phone _____________________
Address ____
Health Insurance Coverage: Company _________________________________ Policy Number ___________________
Address ____
give my consent for the above named physician to disclose medical records and share information regarding medication.

✓ **Signature of Parent/Guardian** ______________________________________ Date _______________________

CONSENT FOR EMERGENCY MEDICATION, TREATMENT AND/OR TRANSPORTATION

In the event that my child/ward should need emergency medical treatment, I authorize school personnel to provide necessary first aid. In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me and school personnel deem it necessary, I authorize school personnel to transport my child/ward to the emergency room of the nearest hospital. I further authorize the hospital and it=s medical staff to provide emergency treatment deemed necessary by them for the well being of my child/ward. I also hereby release the Berrien Regional Education Service Agency, it=s officers, agents, and employees from all liability and all claims which may arise as a result of such emergency treatment and/or transportation as authorized above. I further authorize the district to share any or all of the aforementioned information, with appropriate school staff, for the purpose of providing a safe and healthy environment for my child.

✓ Date: ______________________ Signature of Parent/Guardian: _________________________________