STUDENT INFORMATION --- NURSE'S OFFICE

STUDENT: _____ (First Name) _____ (Last Name) _____ (5-digit ID)

HOMEROOM TEACHER _____ GRADE: ___ BIRTHDATE: _____ ☐ MALE ☐ FEMALE

PHYSICAL ADDRESS: _____ ZIP _____

SUBDIVISION: _____ HOME PHONE: _____

STUDENT RESIDES WITH: _____ EMAIL: _____

PERSONS AUTHORIZED TO PICK UP STUDENT AND PHONE CONTACT INFORMATION (Use name on Driver's License)

Parent/Guardian: _____ Primary #: _____ Other #: _____

Parent/Guardian: _____ Primary #: _____ Other #: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

STUDENT PROTECTION (We are concerned with the safety of your child, please check appropriate box)

☐ **There is not a problem at the present time with mother and/or father picking child up at school.**

☐ **There is a problem with (name) _____ picking child up at school.***

(***Note**: If checked, custody/legal court documents must be on file in the school office.)

List all brothers and sisters living in the household: Name: _____ Age: _____

Name: _____ Age ___ Name: _____ Age: _____

Name: _____ Age ___ Name: _____ Age: _____

HEALTH INFORMATION: list any conditions such as asthma, heart problems, diabetes, epilepsy, severe allergies, ADD or any chronic health condition pertinent to this student. _____

DOES STUDENT WEAR: GLASSES OR CONTACTS ☐ **YES** ☐ **NO** **HEARING AID:** ☐ **YES** ☐ **NO**

MEDICATIONS student is taking/reason: _____

All other over-the-counter medications–including but not limited to Tylenol, Ibuprofen, Aleve, cough drops, antibiotic ointment, oragel – **must be provided and transported to and from the school BY THE PARENT, in its original container and a medication permission form must be filed with the school nurse.**

___ INITIALS **All medication must be in its original & labeled container and brought to clinic by parents/guardian. No medication is allowed on the bus.**

___ INITIALS At the nurse's discretion, only the following clinic medications may be used: Hydrogen Peroxide, Vaseline, and Calamine lotion. **Please notify the school if your child has a condition that will prohibit the use of such items.**

DOCTOR'S NAME: _____ Phone Number: _____

IT IS YOUR RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY CHANGES ON THIS FORM.

I, the undersigned, do hereby authorize the officials of Montgomery ISD to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency. The school officials are hereby authorized to take any action that is deemed necessary in their judgment, for the care of my child. I will not hold the school district responsible for the emergency care and/or transportation of my child.

Parent Signature: _____ **Date:** _____

Note: **The student must remain free of fever for 24 hours before they are allowed to return to school.**