BH Student's Full Name:_____

Emergency Information Form

Please Note: It is in the student's best interest that there is full disclosure regarding **any** issues pertaining to the student's well-being. LGHS cannot be held responsible for any problems that occur due to information that was withheld. Clear communication is vital to a student's success in LGHS. **This information will be kept confidential within the administration & when applicable the dorm mother & counselors.**

*LGHS requires each student to be enrolled in an insurance policy that allows for "sick" visits, or to be enrolled in Illinois public aid. If you need assistance with the application for IPA please be in touch with the school office.

Student's Date of Birth __/__/__

Front of Insurance card	Back of Insurance card

_____

Student's Last Name First Name Middle Social Security Number

_____(_____)_____-_____

Student's Physician Phone Number

_____(_____)_____-_____

Student's Dentist Phone Number

_____(_____)_____-_____

Student's Hospital Phone Number

_____

Name of Insurance Carrier Insurance Number Name of Guarantor

Emergency Medical Treatment

I hereby give permission for my daughter mentioned above to receive any necessary emergency treatment.

Emergency Contacts

(_____)_____-_____ _____ _____ (_____)_____-_____

Father's cell Other emergency contact: Name Relationship Phone Number

(_____)_____-_____ _____ _____ (_____)_____-_____

Mother's cell Other emergency contact: Name Relationship Phone Number

Additional Emergency Contacts

Illinois students whose families reside out of West Rogers Park are required to provide 2 emergency contacts who are residents of WRP. They will be contacted should a medical emergency arise.

_____ _____ (_____)_____-_____
Name Relationship Phone Number

_____ _____ (_____)_____-_____
Name Relationship Phone Number

Care of Students with Asthma

My daughter has asthma: **no** ____ **yes** _____ *If yes, Please provide doctor's prescription*

The school allows the self-administration and self-carry of medications of a student with asthma upon the receipt of a signed parent permission notification and a copy of the prescription, both of which need to be updated yearly.

Care of Students with Diabetes

My daughter has diabetes: **no** ____ **yes** _____ *If yes, Please provide doctor's prescription*

The school allows the self-administration and self-carry of medications of a student with diabetes upon the receipt of a signed parent permission notification and a copy of the prescription, both of which need to be updated yearly.

Care of Students with EpiPen Prescription

My daughter has an EpiPen prescription: **no** ____ **yes** _____ *If yes, Please provide doctor's prescription*

The school allows the self-administration and self-carry of medications of a student with EpiPen prescription upon the receipt of a signed parent permission notification and a copy of the prescription, both of which need to be updated yearly.

Conditions

Does the student have any additional significant medical problem not listed above? Yes____ No ____
If yes, please explain.

_____

_____

Is the student prone to the following: (check all that apply)

- **O** Colds
- **O** Ear Infections
- **O** Regular Headaches
- **O** Migraines
- **O** Strep Throat
- **O** Other _____
- **O** None of the above

How would you treat the above if it should occur?

_____

_____

Please explain what could best be done to keep her healthy.

_____

_____

Allergies

Please list all known allergies. In the comment section, include the severity and the treatment.

Allergies	**Comment**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Sensitivities

Please list all known sensitivities. In the comment section, include the severity and the treatment.

Condition	**Comment**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Medication and their Administration

The school requires that any medication that a student is currently taking, be disclosed to the school, along with the prescription and instructions for proper usage.

The school does not allow the administering of undesignated opioid antagonists or epinephrine pens by staff members.

Is the student on any maintenance medications? **no** ____ **yes** ____ *If yes, Please provide doctor's prescription*
If yes, please explain.

_____

_____

Is the student on any maintenance alternative remedies? **no__yes** __*If yes, Please provide doctor's prescription*
If yes, please explain.

_____

_____

Over the Counter Medications

I grant permission for my daughter, named above, to take the following over-the-counter medications (or an equivalent, including generic) during school hours. (And in her Chicago residence.) I have discussed with her the proper dosage for her weight and age and I have made her aware of the health risks posed by overuse of these medications. I agree not to hold LGHS or the host family responsible for any misuse of the medication by my child.

Medication:	**Allow**	**Do Not Allow**	**Notes:**
Acetaminophen	O	O	_____
Ibuprofen (eg. Advil, Motrin)	O	O	_____
Benadryl	O	O	_____
Sudafed	O	O	_____
Medication cont.:	**Allow**	**Do Not Allow**	**Notes:**
Antacid Tablet (eg. Tums)	O	O	_____
Antibiotic Cream	O	O	_____
Pepto- Bismol	O	O	_____

Permission for Medical Treatment

Emergency

I have adequate medical coverage and insurance and give my daughter permission to attend Lubavitch Girls High School (LGHS) and I agree to indemnify LGHS and its employees for any claim which may hereafter be presented by my daughter as a result of any injuries. In addition, my daughter understands all the safety rules and regulations of LGHS and agrees to conform to them. My daughter's health history is correct and current, so far as I know and my child has permission to engage in all school activities except as described on the official health form. In the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by school officials to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child attending LGHS.

Parent/ Guardian Signature: _____Date:_____

Medication Administration

We, the parents, agree that the school and school personnel incur no liability for injuries occurring when administering a designated asthma medication, an epinephrine auto-injector, an opioid antagonist, or any other prescribed or non-prescribed medication.

Parent/ Guardian Signature: _____Date:_____

I declare that the informant provided above, to the best of my knowledge and belief, accurate and complete.

Please advise that if it comes to our attention that there are health issues that were not disclosed and brought to our attention, we reserve the right to rescind acceptance or to terminate the student's school year.

Parent/ Guardian Signature: _____Date:_____

Do not write below this line

Office use only			
Condition:	Circle one:	Received Prescription? Circle one:	Date of prescription
Asthma	Yes / No	Yes / No	____/____/____
Diabetes	Yes / No	Yes / No	____/____/____
EpiPen prescription	Yes / No	Yes / No	____/____/____
Maintenance medication	Yes / No	Yes / No	____/____/____
Alternative remedies	Yes / No	Yes / No	____/____/____
Other_____	Yes / No	Yes / No	____/____/____