Northland Lutheran High School
Confidential Emergency Care Information

To Parents or Legal Guardians:
In the best organized schools a certain number of accidents and illnesses are bound to occur. The school is responsible for emergency handling of accidents and sudden illness at school, but not for subsequent treatment. Adequate facilities and materials to administer necessary first aid are available in all schools, and NLHS staff is ready to provide care as far as this can be done by a non-medical person. In case of serious accident or illness at school, it may be necessary to secure prompt care for your child at either the doctor's office or hospital. At all times the well-being of your child is considered very important to the school.

One of the greatest problems in handling school emergencies is the inability to reach parents. To meet these situations adequately, it is necessary to have certain information immediately available. In order to have a more effective Health and Safety Program in Marathon County schools, you are requested to complete the report below, and return it to the school promptly. To keep this vital information up-to-date, it is necessary that this report be made every year for each child. Please notify the school whenever any of the information on this report changes.

In a medical emergency where a prompt response is necessary, contact will first be made with the host parents or, if host parents can not be reached, the adults designated by the host parents. At the earliest opportunity, a family member, friend of the family, or agency representative in the United States designated by the biological parents will then be informed of the situation. At that point, biological parents will determine who makes future medical decisions.

Consent to Medical Treatment and Hospital Services

This will certify that I, the undersigned (parent or guardian) of _____ (child's name) do hereby consent and grant permission, should the necessity of medical care arise, to the furnishing of medical treatment and hospital services as ordered or recommended by a qualified physician, including the administration of an anesthetic, laboratory procedures, medical or surgical treatment, X-ray examination, or other hospital services.

_____ _____
Signature of parent or guardian **Date**

_____
Printed name of parent or guardian

Student Name _____ Birthdate ____/____/____ Grade _____
Family **First**

Address _____ City / State / Zip _____

Home Phone _____ Student Cell Phone _____

Medical insurance company and policy number _____

Host Family Contact Information

Name of Host Father _____ Cell Phone _____

Employer _____ Phone _____

Name of Host Mother _____ Cell Phone _____

Employer _____ Phone _____

Person to be called if host parent cannot be reached:

Name _____ Relationship _____ Phone _____

Doctor _____ City _____ Phone _____

Dentist _____ City _____ Phone _____

Parent Contact Information

Please indicate to whom Northland Lutheran High School should communicate any emergency situations.

[ ] I prefer that Northland's faculty or staff communicates the situation with the following person.

_____

Name Relationship Phone Number

[ ] I prefer that a member of the Northland Lutheran High School faculty or staff communicates the situation directly with me.

_____

Name Relationship Phone Number

Confidential Health Information

Student Name _____ Date of Birth _____ Sex M / F

Does student take any medication? _____ (If yes, please complete Prescription or OTC Medication Form)

Is student under medical treatment now? _____ Reason _____

Please check the following:	**YES**	**NO**
Vision:		
Glasses	_____	_____
Contacts	_____	_____
Any eye injury?	_____	_____
If YES, list Incident: _____		
Allergies:		
Seasonal	_____	_____
Medication	_____	_____
If YES, list Medicine: _____		
Food	_____	_____
If YES, list Food: _____		
Asthma	_____	_____
Need Inhaler: _____		
Respiratory symptoms	_____	_____
Other: _____		
Serious Illnesses:		
Rheumatic Fever	_____	_____
Kidney Problems	_____	_____
Tuberculosis	_____	_____
TB Skin Test	_____	_____
Results: _____		
Epilepsy/Convulsion/Seizure	_____	_____
Fainting Spells or Dizziness	_____	_____

	YES	**NO**
Serious Illnesses: (continued)		
Deformity	_____	_____
Bone or Joint	_____	_____
Uses (circle all that apply): Crutches / Braces / Prosthesis		
Cancer	_____	_____
Arthritis	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Insulin: _____		
Any Serious Injuries:	_____	_____
Year & Injury: _____		
Speech Impediment:	_____	_____
Trouble with Sleeping:	_____	_____
Depression or Excessive Worry:	_____	_____
Poor Eating Habits:	_____	_____
Menstrual Disturbances:	_____	_____
Frequent Headaches:	_____	_____
Frequent Colds:	_____	_____
Any Dental Problems:	_____	_____
Frequent Upset Stomach:	_____	_____
Physical Activity Level (circle one):	Active / Inactive	

Any Other Not Listed Above: _____

I give permission for my child's host parents to have access to this health information.

_____ _____

Signature of parent or guardian **Date**