Connecticut Technical High School System

Health History and Emergency Contact Form
E.C. Goodwin Technical High School

For School Nurse's Use Only:	Received:	Valid for Academic Year: to

Student's name: ______________________________________ Date of Birth________________ Shop _________

Is your child covered by Medical Insurance? ☐Yes ☐ No

Medications taken at Home **(daily or as needed):** ____

Medications taken at School: ____

Allergies **(food, medication, insects, latex, environmental):** ☐ No ☐ Yes ________________________________

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EpiPen needed? ☐ No ☐ Yes

☐ I, __________________________ (Parent/Guardian name) give the school nurse permission to speak with my child's doctor about allergy and/or asthma management. Parent/Guardian Initials: ___________ Date: __________

My child has or has had:

☐ Asthma ☐ mild ☐ moderate ☐ severe ☐ exercise induced? Inhaler needed: ☐ Yes ☐ No

☐ Diabetes ☐ Seizures ☐ Brain or neurologic problem ☐ Head injury or concussion ☐ Bleeding disorder or bleeding that's very hard to stop ☐ Stomach or intestinal problems ☐ Heart problems ☐ Bone or joint problems

☐Glasses ☐ Contacts ☐Hearing Aid(s) ☐ Activity or gym restrictions (**requires doctor's note)** ☐ Problem with overeating/weight gain ☐ Problem with under-eating/weight loss ☐ ADD, ADHD or hyperactivity ☐ Depression

☐ Other psychological problem ☐ Frequent absences from school ☐ Problems in school ☐ Problems at home

☐ Other medical problem(s) ____

Please provide more information for any box checked above: ____

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Signature of Parent or Legal Guardian____ Date: _________________

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