Student Emergency Information

West Hartford Non-Public
School Health Services

School Year 2026 - 2027

Class / Grade _____

Student Information

Name: _____ **M / F** **Date of Birth**: _____
Last First Middle **Current Weight _____**

Street Address: _____

City, State and Zip: _____Home Phone _____

Student Lives With: _____ Primary Language: _____

Parent / Guardian Contact Information

(1) Name: _____ Best Contact / ER Number: _____

Employer Name: _____ Work Number: _____

Parent Email:_____

(2) Name: _____ Best Contact / ER Number: _____

Employer Name: _____ Work Number: _____

Parent Email:_____

Emergency Contacts

List two names of persons who will assume temporary care of your student if you cannot be reached and your child needs to leave school due to an illness.

Name: _____ Contact Number: _____ Relationship: _____

Name: _____ Contact Number: _____ Relationship: _____

Does this student have **Health Insurance**: Yes _____ No _____

Please complete other side for Medical Information

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Student Name:_____ **DOB:** _____
Last First Middle

List ALL Allergies: _____

- Does your student have an **Epipen**? Yes _____ No _____

***If yes**, a medical order/action plan and epi pen **must** be submitted to the school nurse*.

Asthma: Does your student have asthma or use an inhaler? Yes _____ No _____

***If Yes**, a medical order/action plan, inhaler **must** be submitted to the school nurse*.

***Note:** In addition to medical authorization, a student who self-carries any emergency medications **MUST** complete a **Self-Carry Contract** with the school nurse.*

Other Medical Conditions or Concerns: _____
_____

List **Medications** taken at home or school**:** _____
_____

Medications for School

***Please note** that **ALL** medications, including over the counter medications, to be given at school **must** be prescribed by a MD, Dentist, APRN, PA, Optometrist and Podiatrist. The order must accompany the medication in its **original** container and be delivered by a parent/guardian to the school nurse or administrator.

Student's Physician: _____ Contact Number: _____

Dentist: _____ Contact Number: _____

*If medically necessary the child will be **transported** to Connecticut Children's or as directed by EMS.

*In the event of a life-threatening event such as **anaphylaxis, Respiratory Distress and/or Opioid Overdose**, the school nurse or, in the absence of the school nurse, a qualified school employee will administer **Epinephrine, Albuterol** and/or an **opioid antagonist**, **Naloxone**, in accordance with the medical orders set forth by the School Medical Advisor, CT PA 14-176 and CT GS section 10-212a(g) unless *written* notice by parent opting out is received by the school nurse.
*I understand that in the event of a serious injury/illness, the school will contact me or my emergency contact. If medical transport is required, I give permission for the school to transport the student for medical care as deemed necessary.
*I understand, and give **permission** for the school nurse to provide health services, education, health screenings mandated by the State of Connecticut and to provide routine first aid according to approved medical guidelines and formulary unless *written* notice by parent is received by the school nurse.

Parent Name (**print**): _____ Student Name: _____

Parent Signature: _____ Date: _____

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