

**ANTIOCH COMMUNITY HIGH SCHOOL  
HEALTH HISTORY AND EMERGENCY INFORMATION**

PARENTS: In order to insure emergency care for a child taken ill or injured at school, the following information is essential. Completing this form each year may seem unnecessary to many parents, but addresses, employment, phone numbers, as well as your child's health, may change from year to year. It must be signed by a parent or guardian.

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

**HEALTH HISTORY:**

Asthma? \_\_\_\_\_ Any restrictions? \_\_\_\_\_

Allergies to food, medicine, insect bites or other? \_\_\_\_\_

Does your child have a hearing loss? \_\_\_\_\_ Wear a hearing aid? \_\_\_\_\_ Wear glasses/contacts? \_\_\_\_\_

Does your child take medicine regularly and for what purpose? \_\_\_\_\_

Does your child have any other significant illness, special problem or disability (include emotional), or use any special equipment such as a brace? Explain: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY INFORMATION**

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

List below other responsible persons to be notified if unable to reach parents:

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

In the event of an emergency rising out of serious illness or injury, permission is hereby granted to transport my son/daughter to a medical facility, if necessary, and to provide necessary treatment. I understand that an attempt will be made by the school administration and/or the attending physician to contact me or my spouse in the most expeditious way possible. If said physician is not able to communicate with me or my spouse, permission is hereby granted to the attending physician to proceed with necessary medical or surgical treatment in the best interest of my son/daughter, and if necessary, to admit him/her to a medical facility. Permission is also granted to the athletic trainer, in the absence of a physician, to provide necessary first aid until such time as a physician is present.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_