TPSD/NMMC Emergency Form

Student's Name_____ **Homeroom Teacher**_____
Last First Middle Initial

Address_____ **Grade**_____ **Gender** _____**Male**_____**Female**

City_____ **State**_____ **Zip**_____ **Birthdate**_____

Social Security Number:_____

What native language is spoken at home? English_____ **What other language?**_____

Daycare name and phone number:_____

Car rider_____ **Walker**_____ **Bus #**_____

1. **Emergency Information**

To serve your child in case of an accident or sudden illness, you must provide the following information for emergency calls. For security reasons, your child will be allowed to leave school only with persons listed on this form.

Mother's Full Name:	Employment Name & Address:	Home #	Cell #	Work #
Father's Full Name:	Employment Name & Address:	Home #	Cell #	Work #
Legal Guardian's Name/Relationship:	Employment Name & Address:	Home #	Cell #	Work #
With whom does the child live?				
Names and ages of other children in household:				

Parent E-mail Addresses:_____ _____

Additionally, the following adults have my permission to be contacted, and to check my child in and out of school. (Names of neighbors, friends, relatives or sitters)

Name:	Relationship to student:	Address:	Home #	Cell #

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2. **Healthcare Information**

This information may be shared with appropriate TPSD staff for your child's best care. Notify the school nurse for any chronic health condition that may require emergency intervention.

a) Student's usual healthcare provider(s):_____ Phone_____

b) Has this child ever been admitted to any of North Mississippi Medical Centers' hospitals or clinics?

(Iuka, Eupora, Hamilton AL, Pontotoc, Tupelo, West Point) Yes❒ No❒

c) Please indicate if you are medically covered by the following:

Medicaid_____ Health Insurance_____ Chips_____ Not covered_____

Dental Insurance Yes ☐ No☐ Vision Insurance Yes ☐ No☐

d) Are your child's eyes checked at least once a year? Yes ☐ No☐

e) Does your child have a dental checkup at least once a year? Yes ☐ No☐

~OVER~

□ My child does not have a medical condition.		
Please list medical conditions your child has NOW	**List any medication(s) to be given at school** ***medication form and doctor's orders required***	**List any medications that the school staff may need to know concerning your child**
□ Asthma ***(Asthma Action Plan required)***	□ Inhaler □ Nebulizer at home/school	
□ Seizure / Epilepsy ***(Medical Action Plan required)***	Last seizure?	
□ Food Allergy ***(Allergic Reaction Care Plan required) name food***	□ Epi-Pen	
□ Insect sting allergy ***(Allergic Reaction Care Plan required)***	□ Epi-Pen	
□ Seasonal allergies pollen dust cats dogs _____		
□ Diabetes ***(Diabetes Medical Action Plan required)***	□ diet □ oral med. □ Insulin □ pump	
□ Hearing problem	__Right hearing aid __Left hearing aid __FM system Deaf Rt_ Left__	
□ Vision problem	__Glasses _ Contacts _ Visually Impaired __Best Correction Blind Rt__ Left__	
Other Medical Conditions / Drug allergies:		

TPSD Consent:

___I hereby authorize officials of the TPSD to directly contact the persons named on this card, and authorize the physicians named above to render such treatment as may be deemed necessary in an emergency for the health of my child. In the event that said physicians, other persons named on this card, or parents cannot be contacted, school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of my child. I will not hold the TPSD financially responsible for the emergency care and/or transportation of said child.

___**The information above is true and correct. I understand that I am to immediately inform the school any time medical information, legal custody, addresses, or phone numbers change.**

_____

Signature of Parent or Legal Guardian Date

NMMC Consent:

I hereby acknowledge that I have been given and received a copy of North Mississippi Medical Center's ("NMMC") Notice of Privacy Practices on behalf of my child. Your acknowledgment does not mean that you agree with our Notice of Privacy Practices or that you have read our Notice of Privacy Practices; it only means that you acknowledge receipt of a copy.

_____

Signature of Parent/Legal Guardian Date Relationship to Student

CONSENT FOR TREATMENT

I, the undersigned, hereby give consent on behalf of, _____, to participate in the NMMC's School Health Center program ("Program"), including any and all medically necessary treatment, health screenings (height, weight, hearing, vision and head lice), as well as any needed emergency intervention. I further understand and consent to having any and all medical information gathered by the Program placed into NMMC's computerized medical record system. I have had the opportunity to ask questions about the Program, its risks, benefits and alternatives and I acknowledge that all such questions have been satisfactorily answered.

By signing below, I hereby authorize and consent to such participation and medically necessary treatment and hereby release, and hold harmless North Mississippi Health Services, Inc. and North Mississippi Medical Center, Inc., (and their directors, officers, employees and agents) from any and all claims, liabilities and damages, which may occur arising out of any and all acts, errors and/or omissions in connection with this consent provided here.

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Signature of Parent/Legal Guardian Date Relationship to Student