EASTERN SUFFOLK BOCES
Educational Services
750 Waverly Avenue
Holtsville, NY 11742

CTE ANNUAL HEALTH HISTORY – EMERGENCY CONSENT FORM

STUDENT'S NAME:	**DOB:**
STUDENT'S ADDRESS:	**HOME PHONE:**
PARENT/PERSON IN PARENTAL RELATION WORK PHONE: Name: Relationship: Phone #: Cell #:	
EMERGENCY CONTACT PERSON: Name: Relationship: Phone #: Name: Relationship: Phone #:	

Known allergies: _____

Chronic conditions: _____

Serious injuries, illnesses, surgeries or hospitalizations:

_____

History of seizures: Yes _____ No _____ Date of last seizure: _____

History of asthma: Yes _____ No _____ Date of last Tetanus: _____

Glasses: Yes _____ No _____ Other: _____

Student is taking the following medication at home and in school: (List additional medications on a separate sheet of paper with student's name on top.)

(1) _____ Dosage _____ Time(s) _____

(2) _____ Dosage _____ Time(s) _____

(3) _____ Dosage _____ Time(s) _____

I hereby give my consent to have my child, _____, examined and treated, if indicated, at the nearest Emergency Room in the event of injury or illness that may occur during school hours while he/she is a student at Eastern Suffolk BOCES.
The school nurse has permission to contact the student's physician at any time. This information may be shared with those persons involved with the care of my child.

Parent/Person in Parental Relation
Signature: _____Date: _____