



# HELLENIC AMERICAN ACADEMY

*Affiliated with Holy Trinity Hellenic Orthodox Church of Chicago*

## SOCRATES HELLENIC AMERICAN DAY SCHOOL

### 2010-2011 EMERGENCY/ALLERGY FORM

STUDENTS LEGAL NAME: \_\_\_\_\_  
(Last) (First) (Middle)

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

*If parents cannot be reached in an emergency call an ENGLISH speaking person within a 5-mile radius*

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CELL: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CELL: \_\_\_\_\_

#### ANNUAL HEALTH UPDATE

1. Does your child have any of the following conditions?  Yes (*If yes, complete all below*)  No

2. Please describe below including individual allergy symptoms.

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Physical Disabilities         | <input type="checkbox"/> Headaches   |
| <input type="checkbox"/> Bee Stings       | <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Migraines   |
| <input type="checkbox"/> Chemicals        | <input type="checkbox"/> Tuberculosis                  | <input type="checkbox"/> Bone/Joint  |
| <input type="checkbox"/> Environmental    | <input type="checkbox"/> Vision/Hearing                | <input type="checkbox"/> ADD         |
| <input type="checkbox"/> Ear infections   | <input type="checkbox"/> Food ( <i>specify</i> ) _____ | <input type="checkbox"/> Seizures    |
| <input type="checkbox"/> Emotional Issues | <input type="checkbox"/> Medications                   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Heart Condition               |                                      |

3. Does your child take medication on a daily basis? \_\_\_\_\_ Required at school? \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribed for: \_\_\_\_\_

4. Does your child need an EpiPen for his/her allergies?  Yes  No

*If yes, please fill out the EPIPEN Release form - obtained from the office*

5. Any other information regarding your child you feel school personnel should know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of emergency, I give the school authorities permission to call the doctor named above and/or the Deerfield Rescue Squad. I give such individuals permission to take the necessary emergency measures. I agree to assume all responsibility and expenses included at this time.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

**PLEASE NOTE:** It is the parent's responsibility to notify the school immediately in writing if ANY information on this form changes.