

Emergency Care Form for the 2015-16 School Year

Please print clearly. Answer ALL questions and return form to your child's school.

Student's Last Name: _____ Student's First Name: _____ Middle: _____

Other Last Name: _____ Home Phone: _____

Street Address: _____ Zip Code: _____

Gender: _____ Date of Birth (Month/Day/Year): _____ Grade: _____ School: _____

Student Resides With

Check all that apply. Please PRINT name(s) and phone number(s) where individual(s) can be reached during the day.

Mother's Name: _____ Phone: _____

Home Cell Work Other

Email Address: _____

This individual is authorized to pick up the above student in an emergency situation.

Father's Name: _____ Phone: _____

Home Cell Work Other

Email Address: _____

This individual is authorized to pick up the above student in an emergency situation.

Guardian's Name: _____ Phone: _____

Home Cell Work Other

Email Address: _____

This individual is authorized to pick up the above student in an emergency situation.

Emergency Contacts

In cases of illness or injury, when neither parent/guardian can be reached, PRINT name(s) of individual(s) who should be contacted. By providing this information, you are giving permission for the person or persons listed below to be contacted in case of an emergency.

Name 1: _____ Phone: _____

Home Cell Work Other

Email Address: _____

This individual is authorized to pick up the above student in an emergency situation.

Name 2: _____ Phone: _____

Home Cell Work Other

Email Address: _____

This individual is authorized to pick up the above student in an emergency situation.

Name 3: _____ Phone: _____

Home Cell Work Other

Email Address: _____

This individual is authorized to pick up the above student in an emergency situation.

Please turn over and complete page 2.

Health Information

If additional room is needed for responses to the items below, please use the space at the bottom of this form.

Check any of the following health condition(s) that your child may have: Asthma Diabetes Epilepsy Allergies (Drugs/Food)

Other condition(s): _____

List allergies to drugs/food: _____

Please list ALL medications your child is presently taking: _____

Does your child have health care insurance (CHIP, Medicaid or Private) coverage?: Yes No

Recommended Vaccines

It is recommended that all children who did not have chickenpox disease get a second chickenpox vaccine. It is also recommended that all children in grades 7–12 get a Tdap vaccine and a Menactra (meningitis) vaccine.

Date of second chickenpox vaccine: _____ **OR** My child had chickenpox disease at age/date: _____

Date of Tdap vaccine: _____ Date of Meningitis vaccine: _____

State Required Physical

The Commonwealth of Pennsylvania mandates that all students have physical examinations in grades K–1, 6 and 9. These will be provided to your child free of charge, or the examination may be done by your family physician or healthcare provider. If your child is in grades K–1, 6 or 9, please answer both statements below:

- 1. I want my child’s physical examination to be completed by the School District. Yes No
- 2. I will have my child’s physical examination to be completed by our family physician or health care provider and sent to the school Nurse. Yes No

Note: Please send record of physical examination to the School Nurse by October 14 of this school year or within one month of enrollment.

Consent to Obtain Health Records

I give consent for the school to obtain immunization information and/or a copy of the last physical from my child’s physician. Yes No

Physician’s Name: _____ Phone Number: _____

Consent for Treatment of Child

In addition to First Aid, the School Nurse Practitioner may treat my child with the following. Check yes or no for each:

Tylenol: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Acetaminophen)</small>	Antacid: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Stomach Ache)</small>	Benadryl: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Allergy Medication)</small>	Ibuprofen: <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(Advil/Motrin)</small>
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By my signature, I give my consent to the school to carry out ALL items indicated by “Yes” responses above.

Parent/Guardian Signature (Full Name): _____ Date: _____

Additional Information (Medical Conditions, Allergies, etc.): _____
