2021-2022 SCHOOL EMERGENCY CARD

PLEASE COMPLETE FRONT and BACK of this paper

Student Name: ________________________ **DOB** ________________ **Grade** _________

Student Address: ____________________ Student Resides With:

____________________ Mother __ Father__ Both__ Guardian ___ Name:

Mother's Name __________________ **Father's Name** __________________

Address ______________________ Address ______________________

______________________ ______________________

Phone (Home) __________________ Phone (Home) __________________

Phone (Work) __________________ Phone (Work) __________________

Phone (Cell) __________________ Phone (Cell) __________________

Email__________________________ Email__________________________

~EMERGENCY CONTACTS~ ***(contact/pickup from school if parent/guardian can't be reached)***

Name ________________________ Number ____________________ Relationship__________

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~HEALTHCARE PROVIDER INFORMATION~

Health Insurance: Private __ CHIP __ Medical Assistance __ None __ Other _________________

Physician ______________________ Phone _______________________ Fax __________________

Dentist ________________________ Phone _______________________ Fax __________________

Eye Doctor ____________________ Phone _______________________ Fax __________________

Specialist ______________________ Phone _______________________ Fax __________________

~EMERGENCY TREATMENT- PLEASE READ AND DATE/SIGN~

In the event of an emergency, I/We grant permission for my/our child to be transported to the nearest hospital. I/We understand that the school will make every effort to contact a parent/guardian first and that all costs will be my/our responsibility. **YES** ______ **NO** ______

PARENT/GUARDIAN SIGNATURE ______________________________ **DATE**_________________

NAME (please print clearly) ____________________________________

OVER

~ALLERGIES~(if <u>Yes</u> please note reaction AND if medication (name/dose) is required at school)

Food Allergy? NO__ YES__________________ Medication Allergy? NO__ YES _____________

Bee Sting Allergy? NO__ YES_______________ Other Allergy? NO__ YES __________________

REACTION__________________ **MEDICATION REQUIRED AT SCHOOL____________________**

~MEDICAL CONDITIONS/ASSISTIVE DEVICES~ (please mark ALL boxes that apply and explain)

ADD/ADHD __ Medication required at school? No __ Yes __ Medication ___________________

Asthma __ Medication required at school? No __ Yes Medication______________________

Cardiac Problems__ Diabetes__ Seizures __Chronic Illness__ Special Conditions ___________________

Explain ____

Glasses __ Contacts __ Hearing Aid(s) __ Wheelchair __ Crutches __ Other _________________

****IF MEDICATION IS REQUIRED AT SCHOOL, PLEASE COMPLETE AND RETURN DOCTORS ORDERS AND MEDICATION PER SCHOOL POLICY BY FIRST DAY OF SCHOOL****

~MEDICATIONS~ (please list ALL medications student takes daily)

Medication	Dosage	Reason Required	Time(s) Required
________________	_______________	___________________	______________
________________	_______________	___________________	______________

~PERMISSION FOR MEDICATION DISPENSED BY NURSE~

____YES ____NO TYLENOL (pain/fever) **____YES ____NO IBUPROFEN (pain/cramps 7&8 Grade only)**

____YES ____NO COUGH DROP **____YES ____NO TUMS (antacid for indigestion)**

____YES ____NO BENADRYL (for allergic reactions only)- Attempt to contact parent/guardian first

____YES ____NO I give permission for the school nurse to obtain/release information regarding medical conditions, medication permissions, immunizations, and physicals from/to my child's health care provider(s) for the **2021-2022** school year.

____YES ____NO I give permission for the school nurse to share medical information, as necessary, with school personnel for the **2021-2022** school year.

I understand that ***<u>ALL</u>*** medications, prescription and non-prescription, ***<u>MUST</u>*** be brought to the Nurse's office to be stored and dispensed as required. All medications must be in an ***<u>ORIGINAL PHARMACY LABELED CONTAINER</u>*** accompanied by written permission from a doctor ***<u>AND</u>*** parent/guardian.

Parent/Guardian Signature____ Date_________________________

EmergencyDismissal

In the event of an emergency, children will be sent home via their traditional form of transportation.

Once notified by the **school districts** that there will be an emergency dismissal, we will send out an electronic communication. If you have any questions please call the school (610-869-9576).