

**CONRAD WEISER AREA SCHOOL DISTRICT
EMERGENCY CONTACT INFORMATION**

This form must be COMPLETED and SIGNED for every student enrolled in the district for the 2015-2016 school year.

STUDENT _____ **GR.** _____ **Teacher** _____ **SVA** _____
(LAST Name) (FIRST Name)

CareerTech (BCTC) _____ **Yes** _____ **EAST** _____ **WEST** _____

Home Address _____ Home Phone _____
(Street address) (City) (Zip)

Is this a change in address from last year? Yes _____ No _____ Birth Date _____

Is any custody information on file at school? _____ Yes _____ No _____ Student lives with _____

Mother's Name _____ E-mail _____

Mother's Address _____ Home Phone # _____

Employer _____ Work Phone # _____ Cell Phone # _____

Father's Name _____ E-mail _____

Father's Address _____ Home Phone # _____

Employer _____ Work Phone # _____ Cell Phone # _____

Guardian's Name _____ E-mail _____

Guardian's Address _____ Home Phone # _____

Employer _____ Work Phone # _____ Cell Phone # _____

If your child needs care & the nurse is unable to reach a parent, please list the names & LOCAL daytime phone numbers of persons to contact during the school day, and to whom your child could be released:

<u>Name and relationship to child</u>	<u>LOCAL Daytime / Work phone/cell phone numbers</u>
1. _____	() _____ () _____
2. _____	() _____ () _____
3. _____	() _____ () _____
4. _____	() _____ () _____

(PLEASE COMPLETE BOTH SIDES OF THIS FORM)

STUDENT NAME - _____

GRADE _____

STUDENT HEALTH INFORMATION - CONFIDENTIAL

STUDENT'S PHYSICIAN:	PHONE:
STUDENT'S DENTIST:	PHONE:
Hospital Preference in case of emergency	

Does student have health insurance? **Yes** **No** If yes, type _____

If no, information on the Children's Health Insurance Program (CHIP) is available from your school nurse.

Does your child have a special health problem or physical limitation that the **School Nurse** needs to be aware of?

Yes **No** **Explain:** _____

Please list any **allergies** (FOOD, BEE STING, LATEX, other) that your child has:

**Permission for Standing Order Medications
Please Check Yes or No**

I give permission for my child to be administered the following by school nursing personnel:

- *Acetaminophen (Tylenol) **Yes** **No**
- *Ibuprofen (Advil, Motrin) **Yes** **No**
- *Antacid Tablets **Yes** **No**
- *Benadryl **Yes** **No**
(for acute allergic reaction only)

Does your child have an **EPI PEN**? Yes / No
If yes, please contact school nurse.

Does your child have **ASTHMA**? Yes / No
Does your child have a **rescue inhaler**? Yes / No

All medications taken during the school day must have a medication form on file in the Nurse's office. Blistex, cough drops, throat lozenges, sting kill

The following first-aid supplies are used as needed: anti-itch products such as hydrocortisone cream, caladryl/ calamine lotion or anti-itch gel, antibiotic ointment, Orajel, swabs & contact solution. If your child can not have any of these items please list them and the reason under the allergy section.

Please list **ALL daily medications** your child takes:

**** May this information be released to your child's teacher or other members of your child's educational/support team?**

Yes **No**

I have read all the information and have answered all the questions to the best of my ability. I hereby authorize the Conrad Weiser Area School District to administer first aid and to secure emergency treatment for my child for any emergency medical situation that may arise at a time when I cannot be immediately contacted.

Parent/Guardian Signature: _____ **Date:** _____

Revised May 2015

PLEASE COMPLETE BOTH SIDES OF THIS FORM