HEALTH OFFICE EMERGENCY CARD –PLEASE SIGN BELOW

Student's Name _____ Birthdate _____ Grade/Room ____/____
Last First Middle Initial

Address _____ Zip _____ Male_____ Female_____

Parent/Guardian #1 _____ Home# (____) _____ E-Mail _____

Employer's Name _____ Work Hours _____ Work# (___)_____ Cell# (___)_____

Parent/Guardian #2 _____ Home# (____) _____ E-Mail_____

Employer's Name _____ Work Hours _____ Work# (___)_____ Cell# (___)_____

List names & relationship of **ALL PEOPLE** that live with the student _____

_____

Name at least **THREE** relatives or friends to contact when parent is unavailable during a student illness, injury, or emergency.
PERSON MUST DRIVE AND BE ABLE TO PICK UP STUDENT DURING THE DAY.

Name_____ Relationship_____ Phone# (___)_____ Cell# (___)_____

Name_____ Relationship_____ Phone# (___)_____ Cell# (___)_____

Name_____ Relationship_____ Phone# (___)_____ Cell# (___)_____

During an emergency, the Emergency Medical Services (EMS-ambulance) will transport the student to a hospital or special facility deemed necessary for the emergency. Since an emergency can occur at any time, requiring us to call the EMS, it is **VERY IMPORTANT** that the certified school nurse be informed if your child has any of the following:

1) **ANY EXISTING MEDICAL OR EMOTIONAL CONDITION(S)**
2) **A NEWLY DIAGNOSED CONDITION(S)**
3) **ANY CHANGE IN A CONDITION**
4) The name of **ANY MEDICINE** taken regularly at home or that will need to be taken in school.
   For the safety of all students, **NO MEDICINE** (prescription or over-the-counter), is permitted to be carried by the student.

Doctor's Name _____ Phone (____)_____ Date of last visit_____

Dentist's Name _____ Phone (____)_____ Date of last visit_____

Eye Doctor's Name _____ Phone (____)_____ Date of last visit_____

If your child **does not** have Health, Dental or Vision Insurance, information is available on free or low cost coverage. Check the information you would like the school nurse to send you: Health Insurance _____ Dental Insurance_____ Vision Coverage _____

List **ANY** medical and/or emotional condition(s) your child has _____

List **ANY** allergies_____ Treatment for allergies _____

List **ANY** medicine taken regularly at home_____ Time taken _____

List **ANY** medicine child is to take in school (requires a doctor's order)_____ Time to be taken_____

The following medicines are available through the Health Office and if you check yes below, the medicine will be given at manufacturer's directions for age/weight & dose. If your child requires the Health Office medicine more than 3 times, the child's doctor would then need to order medicine to be given at school, the parent/guardian would need to complete the school's Medication Form, and the parent/guardian would need to provide the medicine in the original medication container. Check the medicine you permit your child to receive.

Medication	Parent Permission	Dose # 1	Dose #2	Dose #3
Acetaminophen (e.g. Tylenol)	☐ Yes ☐ No	Given_____(nurse's initials)	Given_____(nurse's initials)	Given_____(nurse's initials)
Ibuprofen (e.g. Advil, Motrin)	☐ Yes ☐ No	Given_____(nurse's initials)	Given_____(nurse's initials)	Given_____(nurse's initials)
Antacid (e.g. Tums, Mylanta, Maalox)	☐ Yes ☐ No	Given_____(nurse's initials)	Given_____(nurse's initials)	Given_____(nurse's initials)
Benadryl	☐ Yes ☐ No	Given_____(nurse's initials)	Given_____(nurse's initials)	Given_____(nurse's initials)
Cough Drops	☐ Yes ☐ No	Given_____(nurse's initials)	Given_____(nurse's initials)	Given_____(nurse's initials)

I agree to permit the school to administer this medication to my child. In consideration of the school district's agreement to use good faith efforts to properly administer this medication, the district is hereby relieved from liability for any failure to properly administer this medication. I also authorize the school to contact the physician regarding said medication.

Signature of Parent/Guardian_____ Date_____

2/16 LK