

**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 _____
(LAST Name) (FIRST Name)

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.

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, Blistex, cough drops, throat lozenges, sting kill 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.

Please type your name in the space provided. By typing your name you are signing this document electronically. You agree your electronic signature is the legal equivalent of your manual signature on this document.

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