

Student Emergency Information

*Please fill out one form for each child

*Please complete both sides of this form

Name _____ Grade: _____ DOB: _____

Gender: M F Email Address: _____

Address: _____ City: _____ Zip: _____

Home Phone _____ Whom the child resides with: _____

Parent(s)/guardian(s) names:

Parent 1: _____ Parent 2: _____

Cell # _____ Cell # _____

In the event that my child needs to be dismissed for an injury or illness and I cannot be reached, the following people may pick up my child. **CHILDREN MUST BE PICKED UP WITHIN 30 MINUTES FROM NOTIFICATION**

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

Student's Physician _____ Phone _____

Student's Dentist _____ Phone _____

Hospital Preference _____

Allergies: _____

Medical conditions: _____

Medications: _____

Delegation of Epi-Pens: If the school nurse is not available I give permission for trained school personnel to administer epinephrine to my child in an emergency.

Confidentiality Release: I give permission to the school nurse to share information regarding my child's health with appropriate school personnel, and child's medical providers as needed.

Emergency Treatment Release: In case of an emergency and I cannot be reached, I authorize the school to arrange transportation to the nearest hospital emergency room for treatment.

Signature (custodial parent/guardian) _____ Date _____

OTC Medication Permission Form

Student Name _____ Grade _____ Valid for School Year _____

Our school physician, Catherine Riordan, MD, has provided standing orders and protocols for the medications listed below. The medication/treatment will be administered as needed only after the school nurse evaluates the student's health status. No medication will be dispensed if your child exhibits a fever, or signs of an illness or condition that warrants physician assessment or dismissal from school. Other pain-relief methods such as ice/hot packs, relaxation breathing techniques, and hydration will be used before medication is offered.

Student in PK– Grade 8

	YES	NO
Benadryl (For allergy symptoms)	<input type="checkbox"/>	<input type="checkbox"/>
OTC First Aid Wash (For cuts/scrapes)	<input type="checkbox"/>	<input type="checkbox"/>
A & D Ointment	<input type="checkbox"/>	<input type="checkbox"/>
Bactine	<input type="checkbox"/>	<input type="checkbox"/>

If the student requires Benadryl, the parent/guardian will be contacted.

Student in Grade 5 –Grade 8

There are times when your son/daughter (**Grades 5-8 Only**) may come to the Health Office with a headache, upset stomach, cold symptoms, or pain from orthodontia, sports injury, or menstrual cramps. With your parent permission below, your child may receive the over the counter medication to relieve their symptoms. However, these medications are intended for very infrequent use, if a pattern seems to be forming, we may ask you to supply Any child needing more than three doses per year is required to get a physician's order and provide their own over the counter medication.

	YES	NO
Acetaminophen/Tylenol (For pain relief)	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen/Advil/Motrin (For pain relief)	<input type="checkbox"/>	<input type="checkbox"/>
Cough Drop (For sore throat/cough)	<input type="checkbox"/>	<input type="checkbox"/>
OTC First Aid Wash (For cuts/scrapes)	<input type="checkbox"/>	<input type="checkbox"/>
A & D Ointment	<input type="checkbox"/>	<input type="checkbox"/>
Bactine	<input type="checkbox"/>	<input type="checkbox"/>
I wish to be called every time my child receives a dose of medication	<input type="checkbox"/>	<input type="checkbox"/>

I give permission to the school nurse to administer the above checked medications/treatments to my child as needed.

Parent/Guardian Signature _____ Date _____