Karns City Area School District

Emergency and Health Information Form

Student Name:____Home Phone: ________
Last First Middle

Physical Address:_____________________________/ ________________/ PA / __________
Street Number Street Name City Zip Code

Date of Birth:______ /______/_______ Grade:________ Room No.: ______

Student Lives With: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other ____________________

	Father	*Mother*	*Guardian (Relationship)*
Name:			
Home Phone:			
Work Phone:			
Cell Phone:			
Email Address:			

PLEASE FURNISH THE NAMES OF EMERGENCY CONTACT(S). Other than Parents or Guardians.
List individuals in order of preference who are available and have transportation.

Contact:__________________ Relationship: ____________ Phone: ________________

Contact:__________________ Relationship: ____________ Phone: ________________

STUDENT REVIEW

My signature below indicates I have received and reviewed the Medication Policy Statement and consent to Emergency Medical Transportation and Testing.

MEDICATION POLICY STATEMENT

The law which regulates the administration of medication in the school is the same as that applied to hospitals and other institutions, which is: Medication will be administered only with the written order of the individual's private physician or dentist. Ibuprofen (e.g. Motrin, Advil, etc.) and or acetaminophen (e.g. Tylenol), Cough Drops (Mentholated), Tums/Antacid, Benadryl/Antihistimine, and Ora-gel/Anbesol may be administered to students for mild pain and/or discomfort upon parental permission. The dosage of these analgesics will be administered according to orders as written by the school physician. Dosage will be determined by the student's weight. Dosages that exceed those recommended by the school physician WILL NOT be administered without a written order from the student's personal physician. Prescription medication should be sent to school in the original container accompanied by the parent or guardian requesting the medication be given.

PARENTAL CONSENT TO EMERGENCY
MEDICAL TRANSPORTATION ANDTESTING

In the event of an emergency, your child will be transported via ambulance to the nearest hospital. If an ambulance is necessary, the closest will be called.(If possible, the Karns City Area School District will attempt to contact the parent/guardian prior to transporting an injured or ill student. **Payment for ambulance service to transport the student will not be the responsibility of the Karns City Area School District**.)

Signature of Parent/Guardian Date

Student Name: ______________________ ______________________ ______________________
Last First Middle

Please answer the following questions in order to update your child's health record. This form must be completed by a Parent/Guardian.

1. Does your child have any chronic health conditions? No
Yes please explain and include any surgeries or hospitalizations

____

____

2. Is your child prescribed <u>any</u> medications or treatments? No
Yes, please list medication, dosage, and time

____

____

3. a. Does your child have any life threatening allergies? (foods, insects, medicine, or plants)? No
Yes

b. Does your child have an Epi-Pen* prescribed by his/her physician? No
*Please contact the school nurse regarding your child's Epi-Pen instructions Yes

If yes to either of the above, please list allergies and symptoms ______________________________

____

4. Has your child had any immunizations in the past year? No
Yes If yes, please provide a copy of their immunization record to the health office.

Parent Permission for school nurse to administer the medications below:
*Please note students may <u>not</u> carry or self-administer these medications.

I wish for my child to receive Acetaminophen (Tylenol)	Yes	No
I wish for my child to receive Ibuprofen (Motrin, Advil)	Yes	No
I wish for my child to receive Cough drops(Mentholated).	Yes	No
I wish for my child to receive Antacids/Tums	Yes	No
I wish for my child to receive Benadryl/Antihistimine	Yes	No
I wish for my child to receive Ora-gel/Anbesol	Yes	No

All other medication will require a prescription from child's personal Physician or PCP

Parent/Guardian Signature: ______________________________ Date: ____________

Student's Doctor: ______________________________ Phone: ____________________

Student's Dentist: ______________________________ Phone: ____________________

Health Insurance: ______________________________ Group Number: ____________________

Policy Number: ______________________________