

Seneca Valley School District Health and Emergency Form
(for specific extracurricular activities and overnight trips)

Name of Activity/Trip				
Dates of Activity/Trip		, 20	To	
	Month,	Day		Month, Day

Student's Name: _____ Grade: _____ Date of Birth: _____
Last First Middle

Home Address: _____ State: _____ Zip Code: _____

	Mother/Guardian	Father/Guardian
Name		
Home Phone		
Work Phone		
Cell Phone		

EMERGENCY CONTACTS: List individuals who are willing to transport your student, in order of preference if you cannot be reached.

1) Name		Phone		Relationship	
2) Name		Phone		Relationship	

Health Insurance Company: _____

Group Number: _____ ID Number: _____

Student's Physician: _____ Phone: _____

Student's Dentist: _____ Phone: _____

In case of an emergency requiring immediate medical treatment, I give my permission for the transport of this student to the nearest medical facility. If an ambulance is necessary, the closest available service will be called. If possible, an attempt will be made 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 Seneca Valley School District or associated booster organizations.

Signature of Parent/Guardian _____
Date

Please complete the reverse side of this form.

MEDICAL HISTORY

Please indicate below any of the following conditions that are applicable to your child. If none of these apply, please indicate that at the bottom of the sheet.

- 1) **Life-Threatening Allergies:** YES / NO To What: _____
If so, does your child have an Epi Pen prescribed by the physician? _____
- 2) Environmental/Food Allergies or intolerances: _____

Asthma _____ Triggered by: _____
If so, does your child carry an inhaler? _____ Type: _____
Used approximately how often each day? _____

Nebulizer treatments (type and frequency): _____
- 3) Seizure Disorder _____ Date of last seizure: _____ Symptoms demonstrated: _____
- 4) Diabetes _____ Insulin dependant? _____ Usual Glucometer readings: AM _____ Before meals _____
Bedtime _____
- 5) Chronic joint/muscle problems: _____
Please specify where, reported symptoms and usual treatment: _____

- 6) Abnormal Bleeding Problems: _____
- 7) Menstrual Problems _____ Describe: _____
- 8) Has your child been hospitalized in the past 6 months? _____ If yes, please explain: _____

- 9) Social/Emotional Difficulties that affect daily behavior: _____ If yes, please explain: _____

- 10) Other Conditions or additional information you would like to share: _____

NONE OF THE ABOVE _____

Medications

I agree that all medications that will be in my student's possession are listed below:

	Medication	Dose and Frequency	Reason for Administration
1)			
2)			
3)			

I give permission for my student to self administer these prescription and/or non-prescription medications. I, and the student, understand that distribution of any medication to others is in violation of the Seneca Valley School District medication policy and will cause the student to be subject to disciplinary consequences.

The chaperones carry a limited supply of the non-prescription medications listed below. I give permission for my student to receive, if necessary, the following medication(s) according to recommended product doses.

Please note with a check mark those medications for which you give permission

	Tylenol	Immodium	Sudafed	Robitusin DM
	Ibuprofen	Benadryl	Dramamine	Tums

Signature of Parent/Guardian

Date

Signature of Student

Date

All areas requiring signatures must be signed by the Parent/Guardian and Student where indicated.