SENECA VALLEY SCHOOL DISTRICT

Emergency and Health Information

Student's Name: ____ Home Phone: _____________
Last First Middle

Address:____
Street Town ZIP Code

Birthdate: ______________________ Grade: ____________________ Room No.: _____________

Student Lives With: Mother________ Father________________ Both__________ Other_________

	Father	***Mother***	***Guardian (Relationship)***
Name:	_____________________	____________________	___________________
Place of Employment:	_____________________	____________________	___________________
Business Phone:	_____________________	____________________	___________________
Cell Phone:	_____________________	____________________	___________________
E-mail Address:	_____________________	____________________	___________________

PLEASE FURNISH THE NAMES OF EMERGENCY CONTACT(S). Do not list relatives or neighbors if they have not consented. List individuals in order of preference who are available and have transportation.

Contact:____ Phone: _________________

Contact:____ Phone: _________________

STUDENT HANDBOOK REVIEW

My signature below indicates I have received and reviewed the student handbook, reviewed the Medication Policy Statement, am aware of the Student Accident Insurance, 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. THIS INCLUDES OVER-THE-COUNTER MEDICATIONS.

Prescription medication should be sent to school in the original container accompanied by a note from the parent or guardian requesting the medication be given. School District medication authorization form(s) will then be sent home for parental/physician signature(s) and must be returned the following day.

STUDENT ACCIDENT INSURANCE

District approved student accident insurance is available at a reasonable cost. The coverage includes school time or 24-hour plans. Please contact your student's school office for information.

PARENTAL CONSENT TO EMERGENCY MEDICAL TRANSPORTATION AND TESTING

In case of an emergency requiring immediate medical treatment, I give my permission to transport this student, if necessary, to the ____________________ hospital. If an ambulance is necessary, the closest service will be called. (If possible, the Seneca Valley 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 Seneca Valley School District**.)

____ ____________________________
Signature of Parent/Guardian Date

PLEASE CONTINUE ON OTHER SIDE OF FORM →

It will be helpful to have the following information so that the school can meet any special health needs of your child.

1. Is your child taking medication (oral or by injection)?

   Yes ______ No _____ If yes, what? ____

   Reason for medication: ____

2. Does your child have any special health problems such as asthma, allergies, diet restrictions, seizures or any other health problems/needs?

   Yes ______ No _____ If yes, please explain: ____

   ____

3. Is your child allergic to pesticides and/or herbicides?

   Yes ______ No _____ If yes, please explain: ____

   ____

4. Does your child have any life threatening allergies such as to foods, plants, insects or medicine?

   Yes ______ No _____ If yes, please explain: ____

   ____

PLEASE NOTE: *This question applies to "Life-threatening" allergies. If this applies to your child, contact the school nurse personally as soon as possible regarding your physician's instructions.*

5. Does your child have a bee sting kit or Epi Pen prescribed by his/her physician?

   Yes ______ No _____ If yes, please explain: ____

   ____

6. Has your child required hospital care in the last 12 months?

   Yes ______ No _____ If yes, please explain: ____

   ____

Student's Doctor: ____ Phone: _________________

Student's Dentist: ____ Phone: _________________

Municipality: ____

(Cranberry Township, Forward Township, Jackson Township, Lancaster Township, Evans City Borough, Callery Borough, Harmony Borough, Zelienople Borough, and Seven Fields)

BUS NO.: _________ AM _________ PM NAME OF STOP: ___________________________________

MAM/cfp May 2007