GRADE_____ **EMERGENCY INFORMATION** **_____SCHOOL YEAR**

CONEMAUGH TOWNSHIP AREA SCHOOL DISTRICT

STUDENT NAME_____ SEX _____ Male _____ Female

STREET ADDRESS_____

MAILING ADDRESS (if different than above) _____

PHONE_____BIRTHDATE_____TEACHER_____

*Unlisted numbers will be kept confidential. We MUST have a telephone number to contact parent/guardian.

FATHER'S NAME_____TELEPHONE #_____Email address _____

EMPLOYER_____TELEPHONE #_____

MOTHER'S NAME_____TELEPHONE #_____Email address_____

EMPLOYER_____TELEPHONE #_____

Person with whom pupil lives (if other than parents)_____Relationship_____

If parents are divorced/separated, who has legal/physical custody of the student? _____

List any person(s) NOT permitted to pick up your child _____

List **THREE** contacts **other than** the parent/guardian whom you agree may pick up your child and/or assume temporary care of your child if you cannot be reached.

NAME_____ RELATIONSHIP _____TELEPHONE_____

NAME_____RELATIONSHIP _____TELEPHONE_____

NAME_____RELATIONSHIP _____TELEPHONE_____

BUS # TO SCHOOL _____ NAME/LOCATION OF STOP _____

BUS # FROM SCHOOL _____ NAME/LOCATION OF STOP _____

WILL CHILD ATTEND DAY CARE BEFORE/AFTER SCHOOL? YES _____ NO _____

IF SO, NAME AND PHONE _____

WILL YOUR CHILD BE PICKED UP FROM SCHOOL ON A REGULAR BASIS? YES _____ NO _____ IF SO, BY WHOM? _____

LIST SIBLINGS (and grades) THAT ATTEND CONEMAUGH TOWNSHIP SCHOOLS_____

PLEASE LIST DAILY MEDICATIONS & DOSAGE: _____

P**lease inform the school of any medication changes including short term medications such as antibiotics/pain medications.**

KNOWN ALLERGIES: _____

Please note any special health problems, illnesses, recent accidents/injuries, or other previous condition still under observation or treatment

_____

_____YES_____NO Do you grant permission for medical information to be given confidentially to faculty/administration?

FAMILY DOCTOR_____TELEPHONE # _____

FAMILY DENTIST_____TELEPHONE #_____

HOSPITAL PREFERRED BY FAMILY: _____

We/I, _____ being the parent(s)/guardian(s) of _____, a student in the Conemaugh Township Area School District ("CTASD"), acknowledge and agree that CTASD, and its employees, are not obligated or responsible for dispensing or administering medication(s) to my child during school hours or while my child is on school property. However, We/I hereby specifically request and authorize CTASD to dispense and administer medication(s) to my child during school hours or while on school property. We/ I agree that We/I will provide in writing to CTASD any and all necessary healthcare information that may relate to my child, including, but not limited to, known allergies, health conditions, list of all medications, and those to be administered or dispensed, and dosage information. Fully understanding and appreciating the risks associated with this authorization, We/I further agree to release, indemnify and hold harmless CTASD, and its employees, faculty, administrators and agents, from any and all losses, claims, actions, suits, demands, liability and damages in relation to CTASD dispensing or administering medication(s) to my child during school hours or while my child is on school property.

Signature _____ Date _____

C.T.A.S.D. EMERGENCY INFORMATION REGARDING SCREENINGS, OVER THE COUNTER MEDICATIONS, AND FIRST AID TREATMENTS

The examinations listed below may be done by the student's doctor/dentist. If you wish to have any of the examinations done by your private physician/dentist, please indicate by circling the appropriate number(s). Those examinations NOT circled will be done by the school physician/dentist. NOTE: The examination report MUST be returned to the school nurse for the student's health record.

1. PHYSICAL EXAMINATIONS BY PRIVATE PHYSICIAN FOR STUDENTS IN GRADES KINDERGARTEN, SIX AND ELEVEN.
2. DENTAL EXAMINATIONS BY THE PRIVATE DENTIST FOR STUDENTS IN GRADES KINDERGARTEN, THREE AND SEVEN.
3. SCOLIOSIS SCREENING BY THE PRIVATE PHYSICAN FOR STUDENTS IN GRADES SIX AND SEVEN.

BELOW IS A LIST OF APPROVED MEDICATIONS/TREATMENTS FOR MINOR MEDICAL PROBLEMS. PLEASE CIRCLE THOSE MEDICATIONS/TREATMENTS YOU GIVE APPROVAL FOR YOUR CHILD TO RECEIVE DURING THE SCHOOL YEAR.

PLEASE NOTE THAT PARENTS/GUARDIANS AND/OR 911 WILL BE CONTACTED FOR TRUE MEDICAL EMERGENCIES

☐ **I GIVE APPROVAL FOR ALL THE MEDICATION/TREATMENT LISTED BELOW.**

Tylenol: for pain/fever greater than 100
Antacid Tablets: for indigestion or upset stomach
Chloraseptic Spray: for sore throat
Cepacol lozenges: for sore throat
Cough drops: for cough
Salt water gargle: sore throat
Clear Eyes: for redness/irritation
Contact Solution: for rinsing of soft contacts
Biofreeze/Bengay: for sore muscles
Cotton or warm compress: for earaches
Caladryl/Calamine: for skin irritations
Ivy Dry/Ivarest: for poison ivy, oak or sumac
Hydrocortisone 1% cream: for skin irritations
Oral Benadryl: for severe allergic reactions
Benadryl Lotion: skin irritations
Lidocaine HCL 2%: for minor burns
Orajel: for toothache/gum irritation
Blistex/Vaseline: for dry/chapped lips
Hot/warm water bottle: for menstrual cramps
Epi-Pen/Epi-Pen Jr.: for anaphylaxis/severe allergic reaction
Hydrogen peroxide or Band-Aid Antiseptic Wash: for cleansing wounds
Alcohol 70%: for insect bites or stings, cleansing skin or pierced ear irritations
Ice and/or cold water: for recent injuries, burns, insect bites or stings, headaches
Dry Dressings: for burns, abrasions, lacerations, wounds or infections
Neosporin/Antibiotic ointment: for minor abrasions, cuts, or scrapes
Benzocaine 20% and Menthol 1.0%: for topical anesthetic due to insect bites/stings

A form from a licensed prescriber and consent form from the parent/guardian are required for all over the counter medications not authorized by the school physician in the medication list on the standing orders.

_____ _____

DATE **SIGNATURE**

Updated 6-29-12