TYRONE AREA SCHOOL DISTRICT – HEALTH SUITE EMERGENCY INFORMATION

Please cross out incorrect information, write in any corrections below, sign and return to the Health Suite within five school days.

Student Full Name:	Grade:	HR:	DOB:

Home Address:	City:	County:

These persons may provide transportation and assume responsibility for this child in case of illness or emergency; *parent(s) or guardian(s) should be listed as first two contacts:*

1. Name:	Relationship:	Lives with?	Email:
Home phone:	Cell Phone:	Work Phone:	

2. Name:	Relationship:	Lives with?	Email:
Home phone:	Cell Phone:	Work Phone:	

3. Name:	Relationship:	Lives with?	Email:
Home phone:	Cell Phone:	Work Phone:	

4. Name:	Relationship:	Lives with?	Email:
Home phone:	Cell Phone:	Work Phone:	

After school caregiver, if applicable: ______________________________ Phone: ____________________

Please list name & grade of brothers/sisters who are TASD students: ______________________________

Please list name & birth date of any siblings under the age of five: ______________________________

Physician:	Phone:	Dentist:	Phone:

Health Insurance:

The information above will be shared via our computerized student record system. The medical information below is confidential, but may be shared with other school personnel if necessary to insure the student's health, safety, and classroom success.

Medical conditions, including allergies: ______________________________

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Current medications: ______________________________

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The following medications have been authorized by the school physician for administration in the Health Suite, *with your permission*. Please initial those you wish to be given as needed by the school nurse:

_____ all meds as listed below   _____ no medications   ***OR*** initial individually below:

_____ acetaminophen (generic Tylenol)
_____ ibuprofen (generic Advil)
_____ diphenhydramine (generic Benadryl)
_____ Tums
_____ triple antibiotic ointment
_____ Calamine/Caladryl
_____ hydrocortisone cream
_____lidocaine spray/aloe
_____ Anbesol
_____ Chloraseptic
_____ cough drops

Please notify the school in writing of changes to the above information. Medications cannot be given at school without written consent from a physician. Parents are responsible for their child's transportation from school when he or she is ill.

In the event of an accident or serious illness, and if the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his or her instructions. If it is impossible to contact the physician, the school may make arrangements for transport of your child to the nearest medical facility for necessary treatment.

Date: ____________________   **Signature of Parent/Guardian:** ______________________________