Grade_____ Reading School District Student ID _____

Health Room Emergency Information

School Year ____-____ Teacher/HR _____

Student Name: _____ Birth Date _____ □ Male □ Female

Home Address: _____Parent Cell: _____

Home phone: _____

Mother: _____Email: _____Work phone: _____

Father: _____Email: _____Work phone: _____

Guardian; _____Email: _____Work phone: _____

Preferred Method of Nonemergent Communication: Email __ Phone ___ Home language: _____

Child lives with: Both parents: _____ Father: _____ Mother: _____ Other: _____

Emergency Contacts(Other than Parents)-must be local and available to be contacted

Name and Relationship (to child) Phone Work Phone

1. _____

2._____

Students Doctor/Clinic: _____Phone: _____

Medical Insurance: MA ___Chip___Private: ____**Vision Insurance** Yes:__No:__**Dental Insurance: Yes__No__**

IMPORTANT: Please check which hospital you prefer if your child needs to be transported by ambulance in the event of a serious emergency. Your signature gives permission for emergency treatment; as well as for RSD School Nurses to administer the medications you indicate on this emergency card during school hours, on field trips and after school activities.

__ Reading Hospital __ St. Joseph's Hospital

Parent Signature: _____ Date: _____

Please check yes below if you give permission for the school nurse to give your child this medication in school.

Acetaminophen (Tylenol)	**Yes**		**No**	
Allergy Eye Drops	**Yes**		**No**	
Antacid Tablets (Tums)	**Yes**		**No**	
Benadryl (for hives)	**Yes**		**No**	
Ibuprofen (Advil, Motrin)	**Yes**		**No**	
Kaopectate **(6th – 12th grade only)**	**Yes**		**No**	

FOR CERTIFIED SCHOOL NURSE USE ONLY:

Further Information Requested_____
Med Alert Checked and Updated____
Standing Orders Entered _____
IHP:_____ 504_____

Please Check the following if your child:

Wears: Glasses____Hearing aid_____

Has: Seizures____Diabetes____Asthma____ADHD____

List Allergies: _____

_____

Other Health Problems: _____

Does your child take medication: Yes___No___

Name of medication Dose Time

_____

_____

_____

_____

Medication taken at school

_____

_____

Does your child have epipen?Yes____No____

inhaler?Yes No

Siblings

Name	Grade/age	School