Last Name: ______________________________ First Name: __________________________________ Grade: _______

Superior School Emergency Care/Information Form 2023-24

Student's Legal Name:	Also known as:
Gender:	Grade:
Custodial Information: (if applicable) ☐ N/A ☐ Mother ☐ Father ☐ Joint Non Custodial Parent: ☐ Permission to see ☐ Pick Up Copy of Custody Papers on File? ☐ Yes ☐ No	**Where does the student stay at night?** ☐ In a home you own or rent ☐ Temporarily with another family member ☐ Other (Specify):
PRIMARY HOUSEHOLD (Where student stays most of the time)	
Mailing Address:	**Physical Address:**
Parent Guardian (living in this household): Name: Relation to student: Email: Employer:	**Phone Numbers:** Home: Work: Cell:
Parent Guardian (living in this household): Name: Relation to student: Email: Employer:	**Phone Numbers:** Home: Work: Cell:

All other children living in the primary household:		
Name: DOB: Grade: School Child Attends:	Name: DOB: Grade: School Child Attends:	Name: DOB: Grade: School Child Attends:
Name: DOB: Grade: School Child Attends:	Name: DOB: Grade: School Child Attends:	Name: DOB: Grade: School Child Attends:

SECONDARY HOUSEHOLD (if applicable)	
Mailing Address:	**Physical Address:**
Parent Guardian (living in this household): Name: Relation to student: Employer:	**Contact Information:** Home: Email: Work: Cell:
Parent Guardian (living in this household): Name: Relation to student: Employer:	**Contact Information:** Home: Email: Work: Cell:

EMERGENCY CONTACTS	
Name: Relation to student: Consent to pick up? ☐ Yes ☐ No	**Contact Information:** Home: Email: Cell:
Name: Relation to student: Consent to pick up? ☐ Yes ☐ No	**Phone Numbers:** Home: Cell:

Last Name: ____________________________First Name:________________________________Grade:_______

Authorization for Treatment

I hereby voluntarily consent to emergency treatment, first-aid screening, examinations, and minor treatment as may be deemed necessary. I also voluntarily consent to preventive health screening including vision, hearing, scoliosis, and other screening as may be deemed necessary by the school nurse. ☐**Yes** ☐ **No**

I give my permission for the school nurse and/or other designees to administer (according to protocol) medications (Acetaminophen, Ibuprofen, Tums, Cough Drops, Antibiotic Ointment, Eye Wash and/or 1% Hydrocortisone Cream) according to standing orders and/or completed medication form(s). ☐**Yes** ☐ **No**

When unable to contact parent, guardian, or identified emergency contact, I hereby give my permission to the school to authorize treatment needed, until the parent can be notified. ☐**Yes** ☐ **No**

I understand and authorize that immunization information on my child will be shared with the local public health departments and entered into electronic data systems, the Montana Public Health Data System (PHDS). The intend of an electronic immunization registry is to provide a complete and permanent immunization record for your child.
☐**Yes** ☐ **No**

I give the school permission to text me about my child's medical conditions, screenings, injuries or illness?
☐**Yes** ☐ **No**
If "yes" whom should they contact? Name: Phone Number:

MEDICAL INFORMATION

Student Health Insurance:	☐ None	☐ Healthy MT Kids	☐ Healthy MT Kids Plus (Medicaid)	☐ Private

Student Primary Care Provider:	Name: Clinic:	Phone: Fax:

Health Conditions: (please describe):

My student has a life-threatening medical condition and needs a health care plan at school: ☐ Yes ☐ No
If yes, please contact the school to speak with the school nurse.

Allergies: ☐ Yes ☐ No (If you answered yes, please describe the cause, reaction and treatment):

My student requires an Epi Pen and plan for anaphylactic reactions: ☐ Yes ☐ No
My student has diagnosed food allergies that need to be provided to the kitchen/classroom: ☐ Yes ☐ No
My student requires an inhaler for asthma: ☐ Yes ☐ No, If Yes please describe triggers, medications, & treatment.

If you answered "yes" to any questions in this section please contact the school nurse for appropriate permission forms and to create a plan.

My student requires: **Glasses/Contacts**: ☐ Yes ☐ No **Hearing Aids:** ☐ Yes ☐ No **Knee/Ankle Braces:** ☐ Yes ☐ No

List all medications your child is taking. If medications are needed during the school day please complete the appropriate form for over-the-counter medication or have your primary care provider complete the prescription medication form. Forms must be completed and returned to the office prior to medications being administered at school. Please note, no medication is to be kept in your child's desk, locker, or school bag. All medications will be stored in the office with the exception of inhalers and/or anaphylaxis/emergency medication with proper healthcare provider release.

Parent/Guardian Signature

Signature: ____ Date: ______________________