WESTERN BEAVER COUNTY SCHOOL DISTRICT

EMERGENCY CARE CARD

Student _____ Grade _____ Homeroom _____
(Last) (First) (Middle)

Address _____

Mother's Maiden Name _____ Student's Date of Birth _____

Circle who your child lives with. Mother Father Stepmother Stepfather Grandparent(s)
Other _____

Mother's Name _____ Home Phone_____Cell/Pager_____

Mother's place of employment _____ Phone _____

Father's Name _____Home Phone_____Cell/Pager_____

Father's place of employment _____ Phone _____

Names and grades of brothers and sisters _____
_____

Since the care and treatment of the student is primarily the responsibility of the parent, every effort will be made to contact the parent first.

Please list **Parent Substitutes** who can be contacted regarding student's care in the event a parent cannot be located. *PLEASE NOTE: Only those listed below will be permitted to pick up your child in case of illness or emergency. As per district policy, photo ID may be required.*

Name_____ Relation _____
Phone_____ Address_____

Name_____ Relation _____
Phone_____ Address_____

Name_____ Relation _____
Phone_____ Address_____

Name_____ Relation _____
Phone_____ Address_____

List anyone who is **NOT PERMITTED** to visit/pick up your child from school:

Name _____ Name _____

PLEASE COMPLETE HEALTH INFORMATION QUESTIONAIRE ON BACK →

Jkg 3/10/8

HEALTH INFORMATION

List any **health conditions** that your child has: _____

_____

_____

List any **medications** that your child takes:
At home _____

_____

At School _____

_____

List any **allergies** that your child has and what treatment is needed for reactions.
Environmental allergies _____

_____

Food Allergies _____

_____

Insect/Bee Allergies _____

_____

Do you give permission for your child to receive these Over The Counter medications? WBSD has "standing orders" for these medications. Generic forms may be used.
Circle YES or NO for each item.

Tylenol	YES or NO	Advil	YES or NO	Cough Drops	YES or NO
TUMS	YES or NO	Anbesol/Oragel	YES or NO	Antibiotic ointment	YES or NO
Benadryl (for allergic symptoms)			YES or NO	Insect sting/burn gel	YES or NO

Family Physician _____ Phone _____
Office Address _____

_____ YES. _____ NO Does your child have medical **health care insurance**? If no, information will be sent home concerning the CHIPS program.

_____ YES. _____ NO In the event of a radioactive emergency, do you want your child to receive **potassium iodide** if instructed by public health officials?

_____ YES. _____ NO Do you give your permission for your child to be **photographed or videographed for school publications and school publicity purposes?**

The following **screenings** are mandated by Pennsylvania School Code. Please notify the school nurse in writing if you do not wish to have the screenings done at school.
Vision: All grades Hearing: Kdg through grade 3 plus grades 7 and 11 and all special ed students
Height and Weight: All grades Scoliosis: Grades 6, 7

IF SCHOOL REPRESENTATIVES ARE UNABLE TO CONTACT PARENTS IN THE EVENT OF AN EMERGENCY, THE SCHOOL WILL HAVE YOUR STUDENT TRANSPORTED BY MEDIC RESCUE AMBULANCE SERVICE.

_____ YES. _____ NO I give permission for my child's health information to be shared with school staff and emergency care personnel on a need to know basis.

Parent/Guardian Signature _____ Date _____