

**PUXICO R-8 SCHOOLS - STUDENT EMERGENCY FORM**

School Year: **2020-21**

Student's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Home Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

<p><b>Student Lives With:</b> <i>Check One Below</i>                  Both Parents ____ Mother ____ Father ____                  Grandparents ____ Guardian ____</p>
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**MOTHER'S INFO:**

Mother's Name \_\_\_\_\_ Home Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Works at: \_\_\_\_\_

Work Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Father's Name \_\_\_\_\_

**FATHER'S INFO:**

Home Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Works at: \_\_\_\_\_

Work Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Directions to student's home \_\_\_\_\_

**PLEASE LIST AT LEAST 3 RELATIVES, FRIENDS, OR NEIGHBORS AND THEIR TELEPHONE NUMBERS THAT WE CAN CALL TO PICK YOUR CHILD UP IF WE CANNOT REACH YOU IN THE EVENT OF ILLNESS, INJURY, OR CRISIS/DISASTER SITUATION.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**MEDICAL INFORMATION** – *In the event of an emergency this information needs to be current.*

*(Please notify the school nurse anytime there is a change in student's medications or medical condition)*

<p>List <b><u>ALL</u></b> Medical Conditions (asthma, seizures, ADHD, etc)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>List <b><u>ALLERGIES</u></b> (food, medication &amp; seasonal)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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List **ALL** SURGICAL PROCEDURES \_\_\_\_\_

List any other medical information (broken bones, etc.) \_\_\_\_\_

List ALL **MEDICATIONS** taken by student (*Include before, during and after school-use separate paper if needed*)  
**MEDICATION NAME & DOSAGE** **WHEN TAKEN (TIMES & HOW OFTEN)**

_____	_____
_____	_____
_____	_____

Will your child need to take medication while at school? YES / NO

\*\*\*\*If your child needs medication while at school, you will have to **bring** your child's medication to school and complete a consent form **BEFORE** your child will be given any medication. (This policy applies to prescription and over the counter medications) **DO NOT SEND YOUR CHILD'S MEDICATION ON THE BUS!!!** All prescription medications brought to school **must** be in the original bottle with the proper label. If your child is prescribed a medication that is to given 3 times daily, there is no need to send it to school, it should be given before school, after school, and at bedtime unless the medication is specifically prescribed at a specific time and used for a condition that will directly affect the student's learning.\*\*\*\*

How is health care provided for this student? (please check the one that applies AND complete below)

Private/Work Insurance \_\_\_\_\_ Medicaid \_\_\_\_\_ MC+ \_\_\_\_\_ Self Pay/No Insurance \_\_\_\_\_

Insurance Provider Name \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Student's Doctor \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Student's Dentist \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Hospital Preference \_\_\_\_\_

*Please Circle Yes or No*

Has your child had a comprehensive physical exam in the last 6 months? YES / NO

Has your child had a dental exam in the last 6 months? YES / NO

Does your child have dental sealants on any of their permanent molars? YES / NO

**PARENTS/LEGAL GUARDIANS YOU MUST SIGN BELOW IN THE APPROPRIATE SPACES IF YOU WANT YOUR CHILD TO RECEIVE THE FOLLOWING SERVICES.**

I give the school nurse permission to administer non-aspirin pain reliever (Tylenol or Tums) to my child if needed.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

I give the school nurse permission to administer Ibuprofen to my child if needed.(occasionally & at nurse's discretion)

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Student's with allergies (seasonal, food, or medication):** If you want your child to be given Benadryl, sign below.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**FIRST AID:** Children here at school, when injured, will receive basic first aid. This includes treatment with first aid medications and medical supplies. In the event of a serious emergency, the parent or guardian will be contacted.

**IN CASE OF EMERGENCY, I UNDERSTAND THE SCHOOL WILL TAKE WHATEVER ACTION NECESSARY TO PROVIDE MY CHILD WITH THE PROPER MEDICAL ATTENTION NEEDED. I ALSO VERIFY THAT ALL INFORMATION ABOVE IS CURRENT AND ACCURATE.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_