Keystone Education Center Charter School

Phone (724) 588-2511 ext. 109 **Fax (724) 588-2545**

PLEASE COMPLETE BOTH SIDES AND RETURN TO SCHOOL NURSE

Emergency Information Record

Last Name_____First Name_____M.I._____

Home Address_____

Last School Attended_____

Grade Entering_____Birthdate_____Social Security No._____

In case of illness or injury, contact:

Parent/Guardian:_____Home Phone_____Cell Phone_____

If we cannot be reached, contact:

Neighbor/Relative_____Home Phone_____Cell Phone_____

Neighbor/Relative_____Home Phone_____Cell Phone_____

In case we cannot be reached, notify our family doctor:

Doctor:_____Phone_____

( ) I do give permission to transport by private car or ambulance if necessary.

( ) I do NOT give permission to transport by private car or ambulance.

Hospital of Choice:

( ) Sharon ( ) Shenango Valley ( ) Greenville ( ) Grove City ( ) Other _____

Father's Employer:_____Phone_____

Mother's Employer:_____Phone_____

Health Insurance:_____

Any Special Health Concerns:_____

Any Allergies?_____If yes, please describe treatment_____

_____

Any restrictions on your child's physical activities? If Yes, Please describe.

_____

_____

_____

Significant Medical Conditions (✓)

	Yes	No	If Yes, please explain:
Asthma	☐	☐	_____
Cardiac	☐	☐	_____
Chemical Dependency	☐	☐	_____
Drugs	☐	☐	_____
Alcohol	☐	☐	_____
Diabetes Mellitus	☐	☐	_____
Gastrointestinal Disorder	☐	☐	_____
Hearing Disorder	☐	☐	_____
Hypertension	☐	☐	_____
Neuromuscular Disorder	☐	☐	_____
Orthopedic Condition	☐	☐	_____
Respiratory Illness	☐	☐	_____
Seizure Disorder	☐	☐	_____
Skin Disorder	☐	☐	_____
Vision Disorder	☐	☐	_____
Genitourinary Disorders	☐	☐	_____
Other (Specify)	☐	☐	_____

What Medication(s) is your child taking? _____

Please tell us what the medication is for: _____

Will your child be taking medication at school? (This will require a Doctor's order)

_____

Is there anything else you would like us to know about your child's health? _____

_____

I give my permission for my child to receive the following oral medications at school if needed. Please check:

( ) Ibuprofen (generic Motrin, Advil)
( ) Sudafed (Decongestant)
( ) Immodium
( )Benadryl (allergies)
( ) Maalox or tums (for upset stomach)
( ) Acetaminophen (generic Tylenol)
( ) Robitussin
( ) Visine - AC (Irritated eyes)
( ) Throat Lozenges/cough drops

Please contact school nurse if child will require any other medications to be given at school.

I am aware of the Medication Administration Policy. I consent to have the above information released to appropriate school personnel as needed. I hereby consent to treatment of minor ailments, emergency care, mandated screenings, and examinations by the school nurse, physician and/or state.

Date _____ ***Parent/Guardian Signature*** _____