

BERWICK AREA SCHOOL DISTRICT EMERGENCY FORM

Complete this form in **blue/black ink** and return immediately. It will be kept on file to be used in case of an accident/illness. If your address or phone numbers change- please contact the Nurse and Child Accounting Office at **570-759-6400 ext. 3521**.

Grade _____ Homeroom Teacher _____ Bus # _____

Student's Name _____ **Date of Birth** _____

Address _____

Home Phone Number: _____ Student Resides with: Mother Father Other _____

Call 1st

Parent/Guardian _____

Relationship to student _____

Language Spoken: English Spanish Other _____

Address _____

Cell phone _____

Email address _____

Employer Name _____

Employer Phone _____

Work hours (Ex 8-4:30) _____

May we call Employer number? Y/N _____

Call 2nd

Parent/Guardian _____

Relationship to student _____

Language Spoken: English Spanish Other _____

Address _____

Cell phone _____

Email address _____

Employer Name _____

Employer Phone _____

Work Hours (Ex 8-4:30) _____

May we call Employer number? Y/N _____

Primary Care Physician _____ Physician's Phone _____

May the school nurse call the family physician? Yes No

Does your student have medical insurance? Yes No If yes, what kind _____

List other children who attend school (name, school, and grade).

List other persons who have consented to be responsible for your child if we are unable to contact you. Give this choice **SERIOUS ATTENTION** as someone who would pick up/care for your child in your absence.

1st CHOICE ALTERNATE

Name _____

Address _____

Telephone _____ Cell # _____

Relationship to Student _____

(Relative, neighbor, friend)

Language Spoken: English Spanish Other _____

2nd CHOICE ALTERNATE

Name _____

Address _____

Telephone _____ Cell # _____

Relationship to Student _____

(Relative, neighbor, friend)

Language Spoken: English Spanish Other _____

High School ONLY: Will you give your student permission to walk/drive home, if the nurse calls you? YES/NO

PLEASE COMPLETE AND SIGN THE BACK OF THIS FORM

Parent/Guardian Initials: _____ **Date:** _____

AUTHORIZATION FOR MANDATED PHYSICAL AND DENTAL EXAMS

The Pennsylvania School Health Law requires a complete physical examination of all students *upon original entry into school and in 6th and 11th grades*, and a complete dental examination for all *students upon original entry into school and in 3rd and 7th grade*. Students from other grades may need a physical/dental exam if one was not completed previously. You are encouraged to have this examination completed by your family physician/dentist as they have greater knowledge of your child's medical/dental history.

Physicals (K, 6th, 11th):

- I will have the medical exam given by my family physician and return the completed form to the school nurse by Jan 5th.
- I prefer to have the medical exam given by the school physician.

Dentals (K, 3rd, 7th):

- I will have the dental exam given by my family dentist and return the completed form to the school nurse by Nov 1st.
- I prefer to have the dental exam given by the school dentist.

***I understand that if the above forms are not returned by the dates listed, I am giving passive consent for the school physician/dentist to complete the exams.**

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

STUDENT'S MEDICAL INFORMATION: (Please check all that apply to your child)

- ADHD List current medication: _____
- ASTHMA List current medication: _____
- DIABETES
- HEART CONDITION List restrictions: _____
- HEADACHES List treatment: _____
- SEIZURES List current medication: _____
- OTHER: Please describe: _____
-

ALLERGIES:

- FOOD: Please list _____
- RED DYE
- BEE STING
- OTHER: _____

Symptoms of the Allergic Reaction:

- Hives Rash Runny nose Itchy eyes Wheezing Facial swelling Anaphylaxis

Medication to treat Allergic Reaction: (Ex. Benadryl/Epi Pen) _____

AUTHORIZATION FOR ADMINISTRATION OF POTASSIUM IODIDE

Medication Name: Potassium Iodide; Reason for Administration: Thyroid protection in the event of a release of radioactive iodine

Time Administered: When instructed by public health officials in the event of a radioactive emergency during school hours.

Note: Please consult your family physician to be sure to your child does not have an allergy to iodine.

- YES:** Give my child potassium iodide, when instructed by public health officials, in the event of a radioactive emergency during school hours.
- NO:** Do not give my child potassium iodide, when instructed by public health officials, in the event of a radioactive emergency during school hours.

Student Name: _____ **Grade:** _____

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