School District of Morrisville Emergency Card

Date _____ Teacher_____ Grade _____

Student Name _____ M F Birth date _____
Last First Middle (Circle one)

Address_____ Phone _____

Student lives with: Both parents Mother only Father only Both parents alternately Guardian _____
Circle one Relationship to student

Father/Guardian Name _____ Mother/Guardian Name _____

Father/Guardian Address_____ Mother/Guardian Address_____

Father/Guardian Phone _____ Mother/Guardian Phone_____

Father/Guardian Email _____Mother/Guardian Email _____

Father/Guardian place of employment _____ Phone _____

Mother/ Guardian place of employment _____ Phone _____

Family Physician _____ Address _____ Phone _____

Student has health Insurance yes no Insurance company name _____ Policy #_____

Student has Dental insurance yes no Insurance company name _____ Policy # _____

Hospital choice in case of emergency: 1st _____ 2nd _____ 3rd _____

Emergency contacts (not parents/guardians) to be called in case of emergency, accident, or illness (Must be over 18 years old). Please choose persons willing and able to pick your child up if necessary and you cannot be reached. **Parents/Guardians are called first.**

	Name	Address	Phone	Relationship
1.				
2.				
3.				

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This card serves as permission for treatment in the health office (see below) and medical emergencies. We will make every effort to contact you for emergency treatment needed but in the event you cannot be reached, you grant permission to Morrisville School District to provide treatment for your son/daughter and not hold liable the district or personnel for any omissions relating to care provided.

Signed _____ Date _____

(Parent/Guardian)

All Allergies: _____

Life threatening Allergy: yes/no Medication needed _____

Asthma: yes/no If yes, do they require medication in school: yes/no Medication: _____

Medical Conditions or health issues: _____

_____

Does your child take Medications: yes/no List medication _____

Please initial each statement below: Medication is given after other treatments do not relieve symptoms. No medication is given within the first or last hour of school. Exception is emergency medication only (Epi-pen or inhalers).

I will _____Will not ____ Give permission for Acetaminophen (Tylenol) for minor pain, headache

I will _____Will not ____ Give permission for Ibuprofen (Motrin) for menstrual cramps or Acetaminophen allergy only

I will _____Will not ____ Give permission for Benadryl for minor allergic reactions only not for seasonal allergies relief

I will _____Will not ____ Give permission for Cough drops for cough and sore throat

I will _____Will not ____ Give permission for students K, 1st, 6th, and 11th Pa State mandated physical exam by school doctor

I will _____Will not ____ Give permission for students K, 1st, 3rd, and 7th PA State mandated dental exam by school dentist

_____ I understand that if my child's dental or physical exam is not presented to the school by October 15, he/she will be scheduled with the school dentist or doctor.

_____ I understand I must provide a doctor's note for conditions that prevent student from participating in gyms/sports

_____ Any medication not listed above to be given in school requires a medication administration form and physician prescription

_____ Date _____

(Parent/Guardian)

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