Penn-Trafford School District
Harrison City, PA, 15636

EMERGENCY CARE IN CASE OF SUDDEN ILLNESS OR INJURY

Must be completed in ink by parent/guardian.
Please print all information.

2018 - 2019 Grade:_____ Homeroom & Teacher:_____

Student's Name:_____ D.O.B.:_____
Last Name First Name

Address:_____

City:_____ Zip Code:_____ Home Phone: ( )_____

Connect Ed Number: ( )_____
(The number used for the school-to-parent automated communication system)

Emergency Cell for Text Alert: ( )_____

Bus Route:_____ or Walker/HS Driver _____

Father's Name: _____
Last Name First Name

Cell Phone: ( )_____ Email: _____

Work Phone: ( )_____ Place of employment: _____

Mother's Name:_____

Cell Phone: ( )_____ Email: _____
Last Name First Name

Work Phone: ( )_____ Place of employment: _____

*Please * next to the first parent contact preference.*

With whom does the child live? Mother Father Both Parents Shared
(Circle one) Other: _____
Phone: ( ) _____

Custody Issue? (Circle one) Yes No
Custody papers MUST be on file with the Main Office.

Name the family members/step parent/persons to be called if neither parent can be contacted:

_____ ( ) _____
Name Relationship Phone

_____ ( ) _____
Name Relationship Phone

Who can pick them up in case of an evacuation? (*Up to four names)*

1. _____ 2. _____
3. _____ 4. _____

Does the child go directly home after school? (Circle one) YES NO

If NO, name of care provider:_____ Phone: ( )_____

Family Physician: _____ Phone: ( )_____

Hospital preference in case of emergency transport: _____

PARENT MUST COMPLETE ENTIRE FORM IN INK AND SIGN IN REQUIRED LOCATIONS

(Please complete the back as well)

HEALTH HISTORY

It is absolutely necessary that the nurse be informed of **ANY** medical condition that your child might have **EVERY YEAR**. A copy of this card will be sent with all students who are transported in an ambulance so it is extremely important that the information is accurate. Please answer the following:

Does your child have **ANY** of the following medical conditions? Diabetes, epilepsy or seizure disorder, asthma, heart condition, nose bleeds, hearing or visual impairment, scoliosis, frequent earaches, headaches or other conditions?

Does your child have **ANY** allergies (i.e. bee or insect sting, food, latex, medication, seasonal, environmental? What treatment or medication is needed?

Does your child have any emotional conditions/fears (i.e. school phobia, anxiety attacks, eating disorder, recent traumatic experience such as death, separation or divorce, fear of thunderstorms?

MEDICAL ADMINISTRATION

All medication, **over the counter and prescription**, must have **BOTH** a doctor's order and written parental permission. If you wish for your child to receive medications during school hours, please review the Medication Policy on the School District's web page under Health Services. Contact your School Nurse for any additional questions.

It is the parent's responsibility to inform the nurse/office of **ANY** changes in the child's medical condition or **ANY** change in the information listed on this emergency card. The care of the child is primarily a parental responsibility, and every effort will be made to contact the parents FIRST in the event of an emergency or illness. By signing this card, **I give permission for treatment of my child in the event of an accident or illness and to share this information with the appropriate school and medical personnel to insure the health and safety of my child.**

Signature:_____ Date: _____
(Card must be completed in ink by parent or guardian only)

PENN-TRAFFORD SCHOOL DISTRICT
STANDING ORDERS FOR OVER THE COUNTER MEDICATION ADMINISTRATION

Student Name_____ Grade_____ Homeroom_____

ALLERGIES: _____ Other medications_____

In accordance with the laws governing public school systems, the Commonwealth of Pennsylvania **requires all medication** given in schools to have both a physician order and parental/guardian consent. Our school physician has provided standing orders for students in the Penn-Trafford School District for a limited number of over the counter medications. This means that once we have your consent and signature and you have sent in the medication, the medications circled below may be given. (Note: Administration of **ANY** other medication requires the parent and physician to complete and submit to the nurse, the "Medication Administration Form").

Please indicate your choice for each medication and sign the form below.

A. Parental/Guardian Consent:

I give permission for my child, _____ to receive the following medication ordered below by the school physician during the school day. I understand the medication will be given by the certified school nurse or the designated registered nurse according to the child's age/body weight and standards for administration.

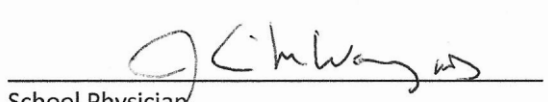
Ibuprofen (Advil/Motrin)	Not to exceed 400mg:	yes	no
Acetaminophen (Tylenol)	Not to exceed 650mg:	yes	no
Diphenhydramine (Benadryl)	Not to exceed 50mg:	yes	no
TUMS	Not to exceed 2 tabs:	yes	no

NOTE: This form must be resubmitted each school year.

Parent/Guardian Signature: _____ Date_____

Parent/Guardian Printed Name: _____ Phone_____

B. Licensed Prescriber Medication Order



School Physician

2/19/18
Date

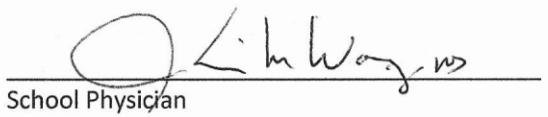
PENN-TRAFFORD SCHOOL DISTRICT
STANDING ORDERS FOR OVER THE COUNTER MEDICATION ADMINISTRATION FOR FIRST AID AND WOUND CARE

The School Nurses of the Penn-Trafford School District, or the designated Registered Nurse, may administer the following over the counter medications to students for first aid and wound care. These over the counter medications will be administered at the discretion of the Certified School Nurse, or the designated Registered Nurse, based on the presenting signs and symptoms of the student:

If there are medications listed below that you **DO NOT WANT YOUR CHILD TO RECEIVE,** please put a line through the item.

Activated charcoal (at direction of Poison Control)
A & D Ointment
Aloe Vera
Anbesol
Antibacterial soap
Antibiotic cream
Bactine
Blistex
Burn jel; cream; spray
Caladryl
Cepacol
Chloraseptic spray
Contact Solution
Eye wash
Glucose tabs
Hydrocortisone Cream
Hydrogen peroxide
Lip balm
Lotramin
Mouth wash
Oil of cloves
Orajel
ProHealth Mouth rinse
Rubbing alcohol (not for wound care)
Salt water mouth rinse/gargle
Second Skin
Sting Kill
Vaseline
Visine eye drops

Note: The Certified School Nurse or the designated Registered Nurse, may make substitutions as needed for basic over the counter treatment of wounds and for First Aid.



School Physician

2/19/18
Date