Wilmington Area School District

300 Wood Street New Wilmington, PA 16142 (724) 656-8866 www.wasd.school

2023-2024 Wilmington Area School District Health Emergency Information Form

Name____ M F____ Grade/Teacher__________Date of Birth________
(Last) (First) (Middle) Sex

☐ **Custody Papers On File – Date**________________________

Parent/Guardian #1 Information Lives with □ Yes □ No
Name____
Last First M.I.
Relationship: ______________________________________
Address__________________________________
City____
State_______________ Zip_______________________
Home Telephone___________________________
Cellular Telephone___________________________________
Employer____
Employer's Address_________________________________
____
Work Telephone ( )_________________________________

Parent/Guardian #2 Information Lives with □ Yes □ No
Name____
Last First M.I.
Relationship: ______________________________________
Address__________________________________
City____
State_______________ Zip_______________________
Home Telephone___________________________
Cellular Telephone___________________________________
Employer____
Employer's Address_________________________________
____
Work Telephone ( )_________________________________

Step Parent:____
Parent/Guardian's email address: ____

When there is an emergency we always try to contact the parent/guardian first. However, please list names, addresses and phone numbers of two relatives, friends or neighbors we might call in case we cannot contact the parent(s)/Guardian(s) listed above. Indicate their relationship to the student.

1. Emergency Contact Person
Relationship____________________________________
Name____
Last First M.I.
Address__________________________________
City____
State_______________ Zip_______________________
Home Telephone___________________________
Cellular Telephone___________________________________

2. Emergency Contact Person
Relationship____________________________________
Name____
Last First M.I.
Address__________________________________
City____
State_______________ Zip_______________________
Home Telephone___________________________
Cellular Telephone___________________________________

Family Physician_______________________________Telephone________________________________
Family Dentist________________________________Telephone________________________________
Do you have a hospital preference: Yes ______ No________, If yes where______________________________

INDICATE MEDICATIONS THAT CAN BE GIVEN TO YOUR CHILD DURING SCHOOL BY THE NURSE:

☐ **BENADRYL(ALLERGIC REACTIONS)** ☐ **TYLENOL/ACETAMINOPHEN** ☐ **IBUPROFEN** ☐ **TUMS**

☐ **COUGH DROPS** ☐ **ORAJEL** ☐ **ANTIBIOTIC OINTMENT**

Does your child have any medical conditions that the school nurse should be aware of (such as asthma, seizures, heart condition, ADD/ADHD)? ☐ YES ☐ NO
If yes, please list: ____
Does your child have allergies?
Medication: ☐ NO ☐ YES MEDICATION NAME: ____________ REACTION: ______________________
Pollens/molds/spores: ☐ NO ☐ YES REACTION: ____
Food: ☐ NO ☐ YES FOOD NAME: ________________ REACTION: ______________________
Plants: ☐ NO ☐ YES REACTION: ____
Insect Stings: ☐ NO ☐ YES REACTION: ____
Other (Please specify): ____
Does child have an EpiPen ____
Child has:
Contacts ☐ Glasses ☐ Hearing Aid ☐ Orthodontic ☐ Braces/Appliances ☐ Prosthesis ☐
Other (Please specify): ____

PLEASE TURN PAGE OVER TO COMPLETE THE OTHER SIDE

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List any medications that your child is currently taking. Include the reason for the medication.

MEDICATION	DOSAGE	REASON

Has your child had any other illness, accident, or broken bones? ☐Yes ☐ No **If yes, explain:** ____________________________

____

Has your child ever been hospitalized or had an operation? ☐Yes ☐No **If yes, explain:** ____________________________

____

Does your child have any dietary restrictions? ____

____

WHEN	NAME OF HOSPITAL	REASON

Has your child had any of the following? Give details.

Speech problems
Vision/ Eye Problems
Hearing/ Ear Problems
Emotional/ Behavioral Problems
Physical Disability or other limitations on physical activities

Please list other children in the family.

Name _______________________ **Date of Birth** ______ **Grade** ___ **Name** _____________________ **Date of Birth** ______ **Grade** ___

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Name _______________________ **Date of Birth** ______ **Grade** ___ **Name** _____________________ **Date of Birth** ______ **Grade** ___

Parent Statement (Must be signed by parent/guardian)

- ✓ By signing below, I acknowledge that I have read the information on the reverse side, have made corrections as necessary, and give permission for the school nurse to administer medications checked on the front of this form.
- ✓ Parental permission is not required for mandated health screenings, therefore by signing below, I understand my child will receive the health screenings as mandated by the School Health Services of the Wilmington School District. Health Screenings are Height, Weight, Vision, Hearing, and Scoliosis as listed in The Wilmington Area School District Handbook.
- ✓ I agree to notify the school district with any medical changes.
- ✓ I hereby authorize you, in the event of an emergency, that is, when you are unable to reach me for authorization or when circumstances require immediate action, to proceed according to good medical practice with treatment of my daughter/son. Also authorize the hospital attending physician, or other health care specialist administering the treatment to release pertinent information to the insurance company assuming coverage for the same.
- ✓ I understand that unless otherwise notified, the school nurse will share this information on a confidential basis with administrators, professional personnel, and support staff members having direct contact with your child to ensure that his/her health and safety is protected.
- ✓ By signing below, I give Wilmington Area School Nurse permission to contact our medical provider/dentist concerning the medical needs of my child and give permission for our medical provider/dentist permission to discuss this need with the Wilmington school nurse for this school year. I may rescind this in writing at any time.

____ _______________________

Parent/Guardian Signature **Date**

Please read and follow the medication administration policy as outlined in the Wilmington Area School District Handbook. Students may NOT keep any type of medication, prescription or nonprescription on their person, in backpacks, lunch boxes, purses or lockers.