STUDENT EMERGENCY CARD

Date_____

Hills Chapel School

Student's Name:_____ Teacher_____

Address:_____ Race:_____DOB:_____

City_____State_____Zip_____ Car:_____Bus #:_____

Preferred Phone Number for Emergency Call Out: _____

Mother's/Guardian's Name:	Home #:_____ Cell #:_____ Pager #:_____	Employer_____ Address:_____ Work #_____ Contact:_____
Father's/Guardian's Name:	Home #:_____ Cell #:_____ Pager #:_____	Employer:_____ Address:_____ Work #_____ Contact:_____

The following persons can assume temporary care of my child if I cannot be reached: ***** only the persons listed below have permission to check the student out of school*****

Name	Address	Phone Numbers:

The following persons are NOT allowed to assume temporary care of my child

Name	Address	Phone Numbers:

HEALTH INFORMATION

Preferred Physician:_____

List any health conditions such as asthma, heart disease, diabetes, seizures, ear or eye problems, or any chronic health condition:_____

<u>If asthma was listed</u>, what conditions trigger an asthma attack?

-over-

List any medications such as breathing treatments or inhalers that are used:

_____

MEDICATION: List any medication and the dosage taken each day:

Medication	Dose

Has your child been hospitalized in the last year? Yes_____ No_____

Reason for hospitalization:_____

ALLERGIES: Please indicate if your child has an allergy to: *medication, ant/bee/wasp stings, food or any other allergies:*

_____

Signs of an allergic reaction: ***(circle any of the reactions below that apply to your child)***

*Systems	*Signs and Symptoms
Mouth	itching, swelling of the lips/tongue or mouth
Throat	itching and/or a sense of tightness in throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Gut	nausea, abdominal cramps, vomiting and/or diarrhea
Lung	shortness of breath, repetitive coughing and/or wheezing
Heart	irregular pulse, passing out

Is this an emergency? Yes No Does this require emergency medication (Epi-pen)? Yes No

*PLEASE NOTE: For your child's safety, as well as others, **DO NOT** send **ANY** medication to school. If a daily medication is needed, obtain the proper paperwork from the office. You MUST BRING the prescribed medication to school; it cannot be sent with the student. The school will not give any medication without the proper paperwork.* ***The school has over the counter medications that may be given with parental permission. You must initial this sheet if you want your child to receive the following medications. Please note – these medications will not be given on a daily basis.***

Please initial beside each medication to give permission for your child to receive:

Tylenol - _____

Tums - _____

Benadryl - _____*(*for stings/reactions only)*

I, the undersigned, do hereby authorize officials of the Prentiss County School District to contact directly the persons named on this card and to authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child.

In the event that physicians, other persons named on this card or parents/guardians cannot be contacted the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

_____ _____

Student's Name: Parent Signature