

SOUTHERN YORK COUNTY SCHOOL DISTRICT
EMERGENCY CARE INFORMATION
_____ School Year

(Complete using blue or black ink)

MEDICAL INFORMATION FOR: _____ ATTENDING: _____

So that we can provide your child with the best possible care, information included on this form will be shared with appropriate staff. You may request that certain information be kept confidential by writing to your child's building principal.

PLEASE INDICATE THOSE MEDICATIONS THAT MAY BE GIVEN TO YOUR CHILD AS DETERMINED BY A SCHOOL NURSE

NO medications may be given Throat Lozenges Tums Tablets Zyrtec
 Benadryl (for allergic reaction) Tylenol (grades 1-12) Ibuprofen (grades 5-12)

Medical Conditions that the School Nurse should be aware of: _____

Does your child have a diagnosed allergy? No _____ / Yes _____

If you answered Yes, please complete the following:

What is your child allergic to? _____ How is it treated? _____

Has your child been prescribed epinephrine? No____ Yes____ (if yes, does he/she self-carry) No____ Yes____

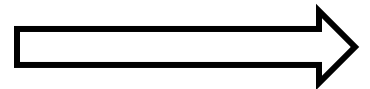
Are accommodations in the classroom or cafeteria needed due to this allergy? No ____ Yes____ (if Yes, see *below)

**A physician's note must be provided annually to the school nurse at the start of each year if accommodations are needed in the classroom/cafeteria.*

I GIVE MY PERMISSION FOR MEDICAL TREATMENT TO BE GIVEN TO MY CHILD IN THE EVENT OF AN EMERGENCY, TRAUMA, OR CONDITION REQUIRING SUCH TREATMENT.

Parent/Guardian Signature: _____ Date: _____ Relation to Student: _____

Please fill out reverse side of this form with relevant Emergency Contact Information for this student.



SOUTHERN YORK COUNTY SCHOOL DISTRICT

EMERGENCY CARE INFORMATION (CONTINUED)

_____ School Year

(Complete using blue or black ink)

CONTACT INFORMATION FOR: _____ ATTENDING: _____

So that we can provide your child with the best possible care, information included on this form will be shared with appropriate staff. You may request that certain information be kept confidential by writing to your child's building principal.

Student Name: _____ Birth Date: _____ Grade: _____
Student Phone: _____ Student Address: _____
City/State: _____ Zip: _____

Parent/Guardian 1

Name: _____ Relation to Student: _____
Address: _____ City/State: _____ Zip: _____
Email: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ SMS Text: Yes__ No__

Parent/Guardian 2

Name: _____ Relation to Student: _____
Address: _____ City/State: _____ Zip: _____
Email: _____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ SMS Text: Yes__ No__

MUST COMPLETE – LOCAL CONTACT OTHER THAN PARENT/GUARDIAN AND/OR RELEASE CHILD TO:

Alternate Emergency Contacts

Contact: _____ Relation: _____ Phone: _____ Release: YES/NO
Contact: _____ Relation: _____ Phone: _____ Release: YES/NO
Contact: _____ Relation: _____ Phone: _____ Release: YES/NO

Is/are the student's parent(s)/guardian(s) an active duty member of a branch of the United States Armed Forces including full-time National Guard?
[] Yes [] No

Please fill out reverse side of this form with relevant Medical Emergency Information for this student.

