WEST ALLEGHENY SCHOOL DISTRICT
EMERGENCY/MEDICAL AUTHORIZATION

Barbara Lecker, R.N., Senior High School, (724) 695-5256
Linda Hart, R.N., Donaldson Elementary (724) 213-1015
Michelle Psaros, R.N., Wilson Elementary, (724) 695-5275
Mary Beth Hill, R.N., Middle School - (724) 695-5234
Carolyn Stultz, R.N., McKee Elementary, (724) 695-5265

PLEASE COMPLETE THE FOLLOWING EMERGENY/MEDICAL INFORMATION
THIS FORM MUST BE RETURNED TO THE NURSE IN ORDER TO AVOID DELAY AT THE TIME OF AN EMERGENCY
****PLEASE BE SURE TO ENTER AREA CODES ALONG WITH TELEPHONE NUMBERS****

STUDENT I.D.#_____ TEACHER_____

NAME _____ GRADE _____

ADDRESS _____ BIRTH DATE _____

_____ EMAIL _____

_____ LOCKER#_____

_____ HOME PHONE ( ) _____

FEMALE/PARENT(Guardian):_____ PHONE# ( ) _____

PLACE OF WORK:_____ WORK# ( ) _____

MALE/PARENT(Guardian):_____ PHONE # ( ) _____

PLACE OF WORK:_____ WORK# ( ) _____

DOCTOR:_____ PHONE# ( ) _____

List the names of neighbors or nearby relatives who will take temporary care of your child if you cannot be reached

EMERG. CONTACT 1:_____ PHONE # ( ) _____

EMERG. CONTACT 2:_____ PHONE # ( ) _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow the instructions. If it impossible to contact this physician, the school may make whatever arrangements are necessary.
I hereby agree to hold the West Allegheny School District and its representative harmless for exercising its judgment in authorizing such emergency medical treatment.

Signature of Parent or guardian:_____ Date_____

(OVER)

In order to update student medical records, please complete the following questions and return to the school health office. If you wish not to share this information with faculty/bus drivers, please inform the nurse's office in writing.

Allergies

☐ Food Allergy ☐ Bee sting allergy ☐ Tree nut allergy ☐ Other_____

This allergy requires use of Ep-pen Auto-Injector/Auvi Q ☐ Yes ☐ No

☐ Special Diet (PKU, Gluten free, etc.)_____

_____Anxiety	_____Asthma	_____Attention Deficit Disorder/Hyperactivity
_____Autism	_____Blood Disorder	_____Cardiac Disorder
_____Celiac Disease	_____Cerebral Palsy	_____Chicken Pox
_____Color Blind	_____History of Concussion	_____Crohn's Disease/Ulcerative Colitis
_____Depression	_____Diabetes	_____Down's Syndrome
_____Eating Disorder	_____Heart Murmur	_____Hearing Impaired
_____Hemophilia	_____Migraine headaches	_____Osgood-Schlatter Disease
_____Prosthetic Devices	_____Scoliosis	_____Rheumatoid Arthritis (Juvenile)
_____Seizure Disorder	_____Spina Bifida	_____Thyroid Disorder
_____Urinary Tract Disorder	_____Vision Impaired	

If you child takes medication on a daily basis, please complete the following information:

Name of Medication:_____

Dosage:_____ Takes in school _____Yes _____No

Reason for medication:_____

PLEASE NOTE: If any medication is required to be given during the school day, a signed permission form must be presented by the physician and the parent. Medication **will not** be given without the above. This includes Tylenol, Advil, Epi-pens/Auvi Q, and over the counter drugs. **Parents must provide the medication**

Please list dates of any serious accidents, operations, concussions, or any other medical conditions:_____

_____

_____

Please list any health conditions or limitations your child has:_____

_____

_____