# 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: I**f 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:_____

_____

_____