PENNCREST School District
PO Box 808
Saegertown, PA 16433
Phone: 814/337-1600

Student EMERGENCY Information
Completed by Parent or Guardian

2019-2020 School Year

Building: ❑CSES ❑CSHS ❑MES ❑MHS ❑SES ❑SHS

STUDENT INFORMATION — Section A

Last Name:		First Name:		Middle Name:
Primary Address:			PO Box:	Apt. No:
City:	State:	Zip:	Birth Sex:	Birth Date (mm/dd/yyyy):
Mailing Address:				
Bus #:	Grade:	Age:	Elementary only: Homeroom #:	Teacher:

Student Lives with (check all that apply): ❑Both Parents full time ❑Father ❑Mother ❑Guardian(s) ❑Caregiver

Father:		**Step-Mother:**	
Address:		Address:	
Home #:	Cell #:	Home #:	Cell #:
Employer:	Work #:	Employer:	Work #:
Email address:			
Mother:		**Step-Father:**	
Address:		Address:	
Home #:	Cell #:	Home #:	Cell #:
Employer:	Work #:	Employer:	Work #:
Email address:			
Guardian (Male):		**Guardian (Female):**	
Relationship to student:		Relationship to student:	
Address:		Address:	
Home #:	Cell #:	Home #:	Cell #:
Employer:	Work #:	Employer:	Work #:

EMERGENCY CONTACT INFORMATION — Section B

In the case of emergency, every attempt will be made to contact the person(s) identified in Section A of this form. In addition, you must provide two (2) alternate contacts (living outside of the primary residence) that would provide transportation or care for your child if he/she becomes ill or injured.

Last Name:	Primary Phone:	Relationship:
First Name:	Cell Phone:	
Last Name:	Primary Phone:	Relationship:
First Name:	Cell Phone:	

BROTHERS/SISTERS — Section C

Last Name	First Name	Age	Grade	School

Continued on back

STUDENT'S NAME: _____ DATE _____

UPDATED MEDICAL HISTORY — Section D

Does your child have:

Any health problems? ❑Yes ❑No If yes, please list: _____

Any Allergies? ❑Yes ❑No If yes, please list: _____

If yes, describe previous reactions: _____

Does your child have any other physical illness or impairment that might affect his/her normal participation or progress in regular school programs or physical education? ❑No ❑Yes

If yes, please explain: _____

If you answered Yes to the above, please submit a statement from your doctor detailing the nature and the duration of the restriction.

Does your child have any health problems which might require emergency treatment while at school? ❑Yes ❑No
(seizures, bee sting or food allergies, bleeding, asthma, heart problems, etc.)

If yes, please explain: _____

Is your child currently taking prescribed medication? ❑Yes ❑No

If yes, please specify:

MEDICATION NAME: _____

DOSAGE: _____

TIME TAKEN: _____

Must medication be administered during school hours? ❑Yes ❑No

If Yes, you must read Policy 210-Use of Medication, and complete the Authorization for Medication to be taken during School Hours form.

Family Doctor:	Phone:
Family Dentist:	Phone:

MEDICAL RELEASE — Section E

Medical information will be shared with school staff as deemed necessary for the safety of your child.

Does your child have medical insurance? ☐ No ☐ Yes ☐ CHIP ☐ Medical Assistance ☐ Private

It is understood that in case of emergency, the school authorities use their own judgement in sending the child to the nearest hospital or a physician most easily accessible if the parent/guardian cannot be reached.

The information provided throughout the enrollment process will be kept confidential and used only for education purposes and reporting as mandated by the State of Pennsylvania. Family Educational Right and Privacy Act (FERPA) is a federal law giving parents the right to inspect all records maintained by the school, upon request. This law also limits the access to these records to those that have 'legitimate educational interest".

_____ _____

Parent Signature *Date*

MB/FEB 2019