BISHOP SHANAHAN H.S. STUDENT EMERGENCY CARD – 2020/21

Emergency Card is required to treat a student in the health room.

Grade_____
1st Period Room #_____

STUDENT: LAST:_____ FIRST/MIDDLE:_____
ID#:_____ BIRTH DATE: _____
ADDRESS: _____CITY: _____ZIP: _____
STUDENT RESIDES WITH: _____

CALL THIS PARENT/GUARDIAN FIRST:
PARENT NAME: _____
HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____
EMAIL ADDRESS: _____

CALL THIS PARENT/GUARDIAN SECOND:
PARENT NAME: _____
HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____
EMAIL ADDRESS: _____

Please provide emergency contacts below, if parent or guardian cannot be reached:
NAME: _____ PHONE: _____
NAME: _____ PHONE: _____
Physician: _____ Phone: _____ Dentist: _____ Phone: _____

MEDICAL HISTORY (In addition to listing serious medical conditions, please contact the nurse by the start of the school year):
ALLERGIES: Please list ALL allergies and the treatment: _____
_____

Does your child require an epipen for the allergy? Yes No **(Parent must provide the epipen and dr. order)**

Please list all medical conditions and medications taken: _____
_____
_____

My child wears: (Please Circle) Glasses Contacts Hearing Aids Other Devices _____

I GIVE MY PERMISSION FOR NURSE TO ADMINISTER:
(Please circle either yes or no)

Medication Name		
Generic Tylenol	**Yes**	**No**
Generic Advil	**Yes**	**No**
Generic Benadryl (given only severe allergic reactions)	**Yes**	**No**
Antacid	**Yes**	**No**

Over-the-Counter & Prescription Medication must be dispensed in the health room and accompanied by a signed note from the parent/guardian and health care provider. All medication must be in the original labeled package. Medication will be administered according to the recommended dosage. No medication will be administered that is not FDA approved.

I hereby give the school nurse permission to release/obtain information regarding immunizations, diagnosis and treatment of health concerns. If school personnel are unable to contact you, they may make whatever arrangements seem necessary in an emergency at no expense to the school.

I acknowledge that medical requests must be provided to the health room 24 hours before the child returns to school so that this information can be communicated with the appropriate staff members.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Please list ALL siblings' names and the schools they attend: