# Chester Community Charter School

**EMERGENCY MEDICAL INFORMATION FORM**
**RETURN TO NURSE**

_____ _____ _____
(**Student's Last Name**) (**Student's First Name**) (**Date of Birth**)

Grade: _____ Teacher: _____Rm#_____ Primary Language: _____Gender_____

_____ _____ _____
(**Parent/Natural Guardian#1**) (**Cell**) (**Work**)

Home Number: _____ Email: _____
Address: _____Apt:_____ City_____Zip Code_____

_____ _____ _____
**(Parent/Natural Guardian #2)** **(Cell)** **(Work)**

**Names of TWO or more people to all if Parent/Guardian(s) cannot be reached.**

1) _____ _____ _____ _____
(Name) (Relationship) (Cell) (Work)
2) _____ _____ _____ _____
(Name) (Relationship) (Cell) (Work)
3) _____ _____ _____ _____
(Name) (Relationship) (Cell) (Work)

**Please list Other Siblings Who Attend Chester Community School**

_____ _____ _____ _____
(Name) (Grade) (Name) (Grade)
_____ _____ _____ _____
(Name) (Grade) (Name) (Grade)

_____ _____
(Family Physician) (Phone Number)

_____ _____
(Family Dentist) (Phone Number)

Does your child have a history of: (Asthma □ Yes No□) (Diabetes: □ Yes No □) (Seizures □ Yes No □) (Heart Condition: □ Yes No □)
(Sickle Cell diagnosed by Doctor: □Yes No □) (ADHD: □ Yes No □) (Seasonal Allergies □ Yes No □)
**Any known Life threatening Allergy documented by Doctor**? □ Yes No □. If yes, please explain _____
_____

***Note:*** **If your child has asthma or a severe allergy, the attached doctor's order form must be completed and returned along with the medication in the original container to the building nurse to ensure student safety. Failure to do so may result in your child losing his/her privilege to attend the current year's field trip.**

## (Please Turn Over)

**EMERGENCY MEDICAL INFORMATION FORM Page 2**

_____ _____ _____

(**Student's Last Name**) (**Student's First Name**) (**Date of Birth**)

List your child's current medications: _____

Does your child need to take this medication during school hours? □Yes No □

If deemed necessary by the nurse, do you authorize the school nurse/physician to give the following medications to your child? Place a ☑ in either the Yes or No column.

| **MEDICATION** | **YES** | **NO** | | **MEDICATIONS** | **YES** | **NO** |
|---|---|---|---|---|---|---|
| Tylenol | | | | Chloraseptic Spray | | |
| Ibuprofen/Motrin | | | | Vaseline/Aquaphor/ Lip guard/ Carmex/Medex | | |
| Tums/Mylanta/Peptobismol Tabs or Liquid | | | | Bacitracin/Polysporin/First Aid Cream/ Antimicrobial Gel | | |
| Benadryl or other Anti-histamines (Severe Allergies Only) | | | | Eye Wash: Sterile Saline/ Purified Water/ or Other | | |
| Epi-pen | | | | Bactine, hydrogen peroxide, antibacterial or antimicrobial soap | | |
| Rescue Inhaler (For current year's diagnosis & Asthma Action Plan on File) | | | | Caladryl, Benadryl Cream/Calamine Lotion & Gels | | |
| Sting Relief Antiseptic & Lidocaine LCL 2.0% | | | | Lotrimin or other Antifungal (With confirmed Diagnosis of Ringworm on File) | | |
| Orajel/Anbesol (With current School year Physical Allergy Status) | | | | | | |

**Permission for School Doctor to perform:** The state Mandated Physical □ Yes No □

These are very basic brief exams. Students are **NOT** required to take off their clothes for the physical and **NO** dental work is done during the dental exam. The dentist looks into the mouth and refers to the family dentist if needed. The exams are only performed if there is no documented physical and/or dental exam on file and your child is in the state mandated grade to receive the exams. These exams are not a substitute for a thorough exam done by your child's health care provider.

**I understand that if neither the parent/guardian, nor the emergency contact(s) listed are reachable, I hereby give my permission to Chester Community Charter School to take whatever action necessary to treat my child in case of an emergency which may include transporting by ambulance to a hospital. I also understand that this transportation cost is the responsibility of the parent/guardian. In addition, I hereby give my authorization for school personnel to obtain any/all medical records as allowed by HIPPA regarding my child so that proper prompt treatment may be obtained.**

_____ **Date:** _____

**Signature of Parent/Guardian**