Struthers City Schools Emergency Medical Form School Year 20_____ - 20_____

The State of Ohio requires the Emergency Medical Form be updated annually

Student Information		
Student Name:	☐ Male ☐ Female Date of Birth:	Grade:
Student Address:	City/State:	Zip:

Residential Parent/Guardian Information (please answer questions A, B, & C)	
A. Student lives with (please X one): ____ Both Parents ____ Mother Only ____ Father Only ____ Other: _____	B. Status of Biological Parents (please X one): ____ Married ____ Divorced ____ Separated ____ Never Married ____ Widowed
C. Who has legal custody for child(ren)(please X one): ____ Both Parents ____ Mother Only ____ Father Only ____ Shared ____ Other: _____	*If separated or divorced, Custody papers are required for student file. For shared custody, please provide addresses of both parents below.*

Legal Parent/Guardian Information	*Legal Parent/Guardian Information*
Name:	Name:
Cell Number:	Cell Number:
Home Number:	Home Number:
Email:	Email:
Relationship to Student:	Relationship to Student:
Is your address the same as the student? _____ Yes _____ No If NO, list your current address, city, state, & zip code:	Is your address the same as the student? _____ Yes _____ No If NO, list your current address, city, state, & zip code:

Emergency/Alternate Contacts In the event you are unable to contact me at the above numbers, you have my permission to contact the following alternates. They have my permission to receive health care information regarding my child and can take my child home during school hours if needed.	
Contact 1 (Other than Parent/Guardian)	*Contact 2 (Other than Parent/Guardian)*
Name:	Name:
Relationship:	Relationship:
Best Contact Number:	Best Contact Number:
Contact 3 (Other than Parent/Guardian)	*Contact 4 (Other than Parent/Guardian)*
Name:	Name:
Relationship:	Relationship:
Best Contact Number:	Best Contact Number:

Emergency Authorization	
In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the named doctor below, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does NOT cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.	
Consent Given: _____ YES (if YES, please list "Medical Contacts" below) **_____ NO** (if NO, please give "Consent Refusal Instructions" below)	
Physician Name:	Physician Phone:
Dentist Name:	Dentist Phone:
Medical Specialist:	Medical Specialist Phone:
Hospital Name:	Hospital Phone:
Facts concerning the child's history including allergies, medications being taken, and any physical impairments such as heart conditions, diabetes, epilepsy, etc., to which a physician or school staff should be alerted:	
Consent Refusal Instructions:	

Parent/Guardian Signature: _____ Date: _____

Struthers City Schools Health Information (School Year 20_____ - 20_____)

Student Name: _____ **Grade:** _____

Your child's health and education are very important to us. The information provided below will be used to facilitate your child's learning. Informing and educating staff about your child's needs will help promote his/her wellbeing. Confidentiality will be maintained and the information will be shared only with those responsible for meeting the child's health care needs.

1. Peanut Allergy?	____ Yes ____ No	Describe reaction: _____ Difficulty breathing? ____Yes ____ No Emergency medication? ____ Yes ____ No Do you eliminate all peanut-containing food? ____ Yes ____ No
2. Other Food Allergy?	____ Yes ____ No	Food: _____ Describe reaction: _____ Difficulty breathing? ____Yes ____ No Emergency medication? ____ Yes ____ No
3. Allergy?	____ Yes ____ No	Medications, seasonal or environmental? Please list: _____ Has allergy required emergency care in the past? ____ Yes ____ No Comments: _____
4. Sting Allergy?	____ Yes ____ No	Bee/insect? _____ Describe reaction: _____ Difficulty breathing? ____ Yes ____ No Emergency medication? ____ Yes ____ No
5. Diabetes?	____ Yes ____ No	DIABETES MANAGEMENT PLAN FROM DOCTOR AND SUPPLIES MUST BE IN THE NURSE'S OFFICE BY THE FIRST DAY OF SCHOOL.
6. Asthma?	____ Yes ____ No	Inhaler? ____ Yes ____ No **If yes, inhaler must be kept in the nurse's office.*
7. Epilepsy/seizures?	____ Yes ____ No	Emergency Medication? ____ Yes ____ No
8. Heart Condition?	____ Yes ____ No	Describe: _____ Activity restrictions? ____ Yes ____ No Describe: _____
9. Other? (Any other health information you would like us to know about your child.)	____ Yes ____ No	Describe: _____

Please check ALL that apply regarding your child's vision and hearing:

Eyes: ____ Lazy Eye ____ Crossed ____ Difficulty Seeing ____ Glasses ____ Contacts

Ears: ____ Frequent Infections ____ Tubes ____ Hearing Difficulty ____ Hearing Aid for: ____ Right Ear ____ Left Ear

Daily Medications Taken by Student

Requirements for Medications to be administered at school:

A. It is strongly recommended to parents, with their physician's counsel, that the medication schedule should be adjusted to avoid administering medication during school hours.

B. If this is not possible, then the Medication Authorization Form must be filed with the respective building nurse's office before the student will be allowed to take medication during school hours. This written and signed request form is to be submitted each school year.

Name of Medication:	Reason for Taking:	Taken Where?
		Home and/or School
		Home and/or School
		Home and/or School

Any additional information regarding your child's health that should be brought to our staff's attention: _____

_____

_____

Parent/Guardian Signature: _____ Date: _____