MANHEIM CENTRAL SCHOOL DISTRICT

281 White Oak Road, Manheim, PA 17545
(717) 664-8540 FAX (717) 664-8528

Student Emergency Information/Verification

Student's Name _____ Grade _____ DOB _____
Last First

Physical Address _____

Mailing Address (if different) _____

PARENT / GUARDIAN

PLEASE INDICATE IF GUARDIANS BELOW ARE OTHER THAN A PARENT

Name Relationship	Name Relationship
Street Address	Street Address
City State Zip	City State Zip
Home Phone Cell Phone Work Phone	Home Phone Cell Phone Work Phone
E-mail	E-mail
Employer Name	Employer Name

ALTERNATE CONTACTS

TO BE CONTACTED IF SCHOOL IS UNABLE TO REACH A PARENT/GUARDIAN

Name	Phone	Relationship to Student

CUSTODY INFORMATION

In order for the school to maintain the safety and confidentiality of our students, please check the following box. All information will be kept confidential.

_____ There is/will be a current custody agreement on file in the school office (including PFAs).

In order for agreements to be followed, a copy must be in the school office.

ALERTNOW CONTACT NUMBERS

AlertNow is a rapid, parent notification system. The number that you list as **CONTACT 1** and **CONTACT 2** will be the number that is contacted for mundane events such as weather-related school closures, reminders about parent conferences or report cards. These numbers should be the parent/guardian's cell or home numbers. In the case of a school-wide or district-wide emergency or an unplanned early dismissal, the **AlertNow** system will call ALL Contact Numbers listed below. You do not have to list five numbers.

	PHONE NUMBER
Contact 1	
Contact 2	
Contact 3	
Contact 4	
Contact 5	

CENSUS - Please list ALL MEMBERS in the household (including the student)

NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT
NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT
NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT
NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT
NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT
NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT
NAME	DOB	AGE	GRADE	SCHOOL NOW ATTENDING	RELATIONSHIP TO STUDENT

PHOTO RELEASE INFORMATION

_______ YES, I give my permission to Manheim Central School District to use photographs, interviews or video tapes of my child for school district publications

_______ NO, I do not give my permission YEARBOOK _____ YES _____ NO

I understand and agree that there will be no compensation for use of these written or visual materials. I also agree to release and discharge Manheim Central School District from all claims and demands of any nature whatsoever, arising from or with respect to the use of any photographs, interviews, movies or videotapes.

MEDICAL INFORMATION

PLEASE LIST ANY MEDICATION TAKEN EITHER AT HOME OR SCHOOL

MEDICATION	DOSAGE	TIME TAKEN	REASON

HAS YOUR CHILD HAD ANY RECENT IMMUNIZATIONS? _____ Yes ____ No

IMMUNIZATION	DATE GIVEN

DOES YOUR CHILD WEAR GLASSES/CORRECTIVE LENSES? _____ Yes ____ No

DOES YOUR CHILD HAVE ALLERGIES TO MEDICATION, FOOD, BEE STINGS, etc.? _____ Yes

PHYSICIAN INFORMATION

Family Physician _____ Phone No. _____

Family Dentist _____ Phone No. _____

Preferred Hospital _____ Insurance Co. _____

_____ Access _____ No Insurance

In case of accident or serious illness, parent/guardian or emergency contact person will be notified. I hereby authorize school personnel to act for me according to their best judgment in any emergency requiring medical attention.

Parent Signature _____ Date _____

***Please Note**: For the safety and well being of each child, information on this form will be shared with school personnel on a need to know basis only.*

REQUIRED PHYSICAL/DENTAL EXAMINATION FOR ENTRY INTO SCHOOL

Kindergarten, Sixth and Eleventh Grades

The PA School Health law requires children upon original entry to school and in the 6TH and 11TH grades to have a complete physical exam.
The PA School Health law requires children upon original entry to school and in the 3rd and 7th grades to have a dental exam.

Please check one of the following:

_____ I wish to have my family doctor examine my child at my own expense.

_____ I wish to have the school doctor examine my child.

_____ I wish to have the school dentist examine my child.

Parent Signature _____Date _____

MEDICATION AUTHORIZATION

Per guidelines on MCSD Health Services Standing Orders, the school nurse will administer the following medication as needed ONLY with your authorization: Tylenol, Ibuprofen (Advil, Motrin, Nuprin), Benadryl – age/weight appro-priate doses, Antacid for stomach upset, Anbesol and Visine. (throat lozenges – middle and high school students only)

CHECK ONE BOX ONLY:

☐ I authorize the school nurse to administer any of the above listed medications

☐ I authorize the school nurse to administer only the following medications: _____

☐ Please call be BEFORE administering any medication

HEALTH HISTORY

____ Yes ____ No Is your child under treatment for a skin problem (ex: psoriasis, eczema)? If so, what treatment will be needed at school? _____

____ Yes ____ No Does your child have any trouble with his/her ears or hearing? Does child have hearing aids? Will child require special seating? _____

____ Yes ____ No Does child get frequent colds or throat infections with a fever? Were child's tonsils removed? ____

____ Yes ____ No Was child ever diagnosed with pneumonia? If yes, when? _____

____ Yes ____ No Has child ever had a convulsion or fit (seizure)? If yes, what type _____
Medication child is on? _____. What special restrictions, meds or care will need to be provided at school for child? _____

____ Yes ____ No Does child complain frequently of headaches? If yes, what medication or special care will be needed at school? _____

____ Yes ____ No Has child ever had a fainting spell?
____ Yes ____ No If yes, was child treated by a doctor? Restrictions at school _____

____ Yes ____ No Does child have a heart murmur that requires doctor's care? If yes, please list restrictions or special care needed at school _____

____ Yes ____ No Does child have asthma or wheezing? If yes, list medication or inhaler(s) needed at school
_____

____ Yes ____ No If your child toilet trained? If no, describe _____
____ Yes ____ No Is constipation a problem for your child? Does child have bladder or kidney problems? _____
If yes, please describe _____
Special care needed at school _____

____ Yes ____ No Has child been diagnosed with juvenile rheumatoid arthritis? If yes, please indicate care required at school _____
____ Yes ____ No Does child have frequent trouble sleeping?

____ Yes ____ No Is child Diabetic? If yes, when was child diagnosed and what special care is needed at school?
_____

____ Yes ____ No Has child been diagnosed with ADD or ADHD or another condition? If yes, please describe
_____
Special care or treatment needed at school _____
Medications _____

____ Yes ____ No Has child been diagnosed with Tourette's syndrome?

____ Yes ____ No Has child been diagnosed or treated for tuberculosis?

____ Yes ____ No Has child ever been in the hospital or had an operation? If yes, indicate when and what for.
_____ _____

____ Yes ____ No Has child had other illnesses, accidents or fractured bones? If yes, please describe _____
_____

____ Yes ____ No Does child require any other restrictions, special care or medications at school other than listed above? If yes, please describe _____

_____ _____ _____
PARENT SIGNATURE DATE STUDENT NAME