Student Name: _____ **Birth Date:** ___/___/_____ ☐ Male ☐ Female
Last First

HARRISBURG SCHOOL DISTRICT HEALTH ROOM EMERGENCY CARD

SCHOOL YEAR _____ GRADE _____ HR _____ TEACHER_____

Home Address _____Home Phone _____

Mother's Name _____Wk Phone_____ Cell_____

Father's Name _____ Wk Phone _____ Cell_____

Or Guardian's Name _____Wk Phone _____ Cell_____

Emergency Contacts (Other Than Parents or Guardian)

Name and Relationship (to Student)	Home Phone	Other Phones
1.		
2.		

***PLEASE NOTE**: Any person listed as a contact may be called unless we are otherwise instructed.

Student's Physician and Phone Number: Dr. _____ (717) _____-_____	**Student's Dentist and Phone Number:** Dr. _____ (717) _____-_____
Insurance Company: ☐ Medical Assistance ☐ CHIP ☐ None ☐ Other_____	**When did your child last see the doctor and dentist?** Date(s) seen: Doctor _____ Dentist_____

IMPORTANT NOTE: By signing this card you are giving permission for the following:

1. The Harrisburg School District may exchange medical and dental information with your child's physician and dentist and may share health information with other professionals as needed in support of the education process.
2. In the event of a serious emergency (which may require evaluation of your child at a hospital) 911 may be called and your child may need to be transported to the hospital by ambulance. This service is **NOT** paid for by the school district.

HEALTH HISTORY UPDATE

- List any serious illness, operation, injury, broken bones or newly diagnosed condition such as asthma, sickle cell, diabetes, etc.

_____

- List any SPECIAL HEALTH PROBLEM or PHYSICAL LIMITATION that the school needs to be aware of:

_____

- List any SEVERE ALLERGY (bee sting, medication, food, other):

_____

- List all medication(s) and dosage(s) your child is taking:

_____

- List any other concerns or situations which may affect your child's success in school:

_____

SIBLING INFORMATION (Sisters / Brothers)		
Name (Last, First)	Age/Grade	School

PLEASE READ, COMPLETE, & SIGN BELOW:

1). My child may receive the appropriate dosage of Potassium Iodide per doctor's order in the event of a nuclear emergency.

Circle one: Yes or No

2 Over the counter meds that your child may receive at school: Circle Yes or No below:

Acetaminophen (Tylenol) : Yes or No
Hydrocortisone cream : Yes or No
Ibuprofen(Advil): Yes or No
Tums: Yes or No

X_____ _____

Parent/Guardian Signature **Date**

DOCUMENTATION

Please Note: No over-the-counter medications will be given to a student for more than three (3) consecutive days or for more than three (3) doses per school quarter for the same condition.

OTC Medication Administration Documentation

Date	Time	Medication / Dosage	Reason Given	Comments	Initials

Signature	Initials
Signature	Initials
Signature	Initials
Signature	Initials