Seneca Valley School District Health and Emergency Form

(for specific extracurricular activities and overnight trips)

Name of Activity/Trip:			
Dates of Activity/Trip:		**To:**	

Student's Name:____ Grade:______ DOB:_______
Last First Middle

Home Address: ____ State:_______ Zip:________

	Mother/Guardian	**Father/Guardian**
Name:		
Home Phone:		
Work Phone:		
Cell Phone:		

EMERGENCY CONTACTS: List individuals who are willing to transport your student, in order of preference if you cannot be reached.

Name	Phone	Relationship
1.		
2.		

Health Insurance Company:____

Group Number: ______________________________ ID Number:___________________

Student's Physician:________________________________ Phone:________________________

Student's Dentist:__________________________________ Phone:________________________

In case of an emergency requiring immediate medical treatment, I give my permission for the transport of this student to the nearest medical facility. If an ambulance is necessary, the closest available service will be called. If possible, an attempt will be made to contact the parent/guardian prior to transporting an injured or ill student. Payment for ambulance service to transport the student will not be the responsibility of Seneca Valley School District or associated booster organizations.

____ ________________________

Signature of Parent/Guardian Date

Please complete the next form.

MEDICAL HISTORY

Please indicate below any of the following conditions that are applicable to your child. If none of these apply, please indicate that at the bottom of the sheet.

1) **Life-Threatening Allergies**: YES / NO To What:________________________________
   If so, does your child have an Epi Pen prescribed by the physician?___________________________
2) Environmental/Food Allergies or intolerances:____
   ____
   Asthma _________ Triggered by:____
   _______ If so, does your child carry an inhaler?________ Type:_________________________
   _______ Used approximately how often each day?_____________________________________
   ____
   _______ Nebulizer treatments (type and frequency):_________________________________
   ____
3) Seizure Disorder ______________________ Date of last seizure:___________________________
   Symptoms demonstrated:____
4) Diabetes ____________________________ Insulin dependent? ___________________________
   Usual Glucometer readings: AM__________ Before meals ________ Bedtime ____________
5) Chronic joint/muscle problems:____
   Please specify where, reported symptoms and usual treatment:______________________________
   ____
6) Abnormal Bleeding Problems: ____
7) Menstrual Problems _____________ Describe:____
8) Has your child been hospitalized in the past 6 months?_____ If yes, please explain:______________
   ____
9) Social/Emotional Difficulties that affect daily behavior:___________ If yes, please explain:________
   ____
10) Other Conditions or additional information you would like to share:___________________________
   ____

NONE OF THE ABOVE:__________ Signature of Parent/Guardian:___________________________

<u>MEDICATIONS</u>

I give permission for my student to self-administer these prescription and/or non-prescription medications. I, and the student, understand that distribution of any medication to others is in violation of the Seneca Valley School District medication policy and will cause the student to be subject to disciplinary consequences.

I agree that all medications that will be in my student's possession are listed below:

	Medication	Dose and Frequency	Reason for Administration
1.			
2.			
3.			
4.			
5.			
6.			

____ ______________
Signature of Parent/Guardian Date

____ ______________
Signature of Student Date

All areas requiring signatures must be signed by the Parent/Guardian and Student where indicated.