Muhlenberg School District
HEALTH SERVICES EMERGENCY INFORMATION

English

Student's Name: DOB: Gender: Grade:

Mailing Address:

Physical Address (if different):

Note any corrections:

Parent/Guardian Name (Priority #1): Relationship:

Email: Cell: Work:

Note any corrections for priority #1:

Parent/Guardian Name (Priority #2): Relationship:

Mailing Address (if different):

Email: Cell: Work:

Note any corrections for priority #2:

If parents are divorced or separated, who has legal physical custody? Parents should notify the district immediately if there is a change.

Joint ☐ Mother ☐ Father ☐ Guardian ☐ Comment:

In case of illness, emergency or accident and parent/guardian cannot be reached; the following adults are authorized to act on behalf of the parent/guardian:

Live in Household	Priority	Emergency Contact Name	Relationship	Phone	Note any corrections

Children in Household Attending School	Grade	Children in Household Attending School	Grade

Yes ☐ No ☐ *** I give my permission to share necessary medical information with appropriate staff who work directly with my child in the interest of their health, safety, and welfare.**

Yes ☐ No ☐ ****I give permission for the Muhlenberg School District Health Services nursing staff to administer over-the-counter medications such as acetaminophen (Tylenol), ibuprofen (Motrin), chewable antacid tablets, topical first aid products, and/or emergency medications as needed per the written standing orders from the school physician consultant.**

Medication Allergies (list the reaction):

YES	NO	Health Condition (diagnosed by medical provider)	If yes, please list explanation and the medication and/or treatment below:
☐	☐	ADD/ADHD	Medicine?
☐	☐	Asthma***	Inhaler?
☐	☐	Diabetes*** Type ☐	Explain:
☐	☐	Migraines***	Explain:
☐	☐	Food Allergy***	List the food and the reaction:
☐	☐	Drug Allergy	List the medicine & the reaction
☐	☐	Life Threatening Bee Allergy Requiring Epi-Pen**	List the reaction:
☐	☐	G6PD***	List triggers:
☐	☐	Seizure/Epilepsy Disorder***	Last seizure:
☐	☐	Vision Issue	Has prescribed: ☐ Glasses or ☐ Contacts
☐	☐	Hearing Issue/Hearing aid?	Hearing aid? ☐ Yes ☐ No
☐	☐	Emotional or Behavioral Issue	Explain:
☐	☐	Cardiac (heart) Issue	Explain:
☐	☐	Head Injury/Concussion	Explain:
☐	☐	Serious or Chronic Illness	Explain:
☐	☐	Serious Operation(s)	Explain:
☐	☐	Other	Explain:
☐	☐	Bleeding Disorders/Cooley's Anemia	
☐	☐	Cerebral Palsy	
☐	☐	Cystic Fibrosis	
☐	☐	Sickle Cell Disease	
☐	☐	Spina Bifida	
☐	☐	Tourette's Syndrome	

*****Emergency/Action Plan for care during school needs to be completed by child's Medical Provider.**
These forms are available through the Health Services website or the school nurse.

List any medications your child is presently taking if not listed above Name of Medication:	Dosage	How Often	Reason for takeing medicine

***IMPORTANT: Please check which hospital you prefer if your child needs to be transported by ambulance in case of emergency. Your signature gives permission for emergency treatment; as well as for MSD nurses to administer medications as directed. ☐ Reading Hospital ☐ St. Joseph's Hospital

Parent Signature: _____ Date: _____