HERMITAGE SCHOOL DISTRICT
EDUCATIONAL RECORD EMERGENCY INFORMATION

Teacher/Homeroom_____
Grade _____

1. _____/_____/_____
Student Name: Last, First, Middle Birth date **Home** Phone

_____/_____/_____/_____
Address: House Number Street City State Zip

2. _____/_____/_____/_____
Mother/Guardian Name: Cell Phone Work Place Work Phone

_____/_____/_____/_____
Father/Guardian Name: Cell Phone Work Place Work Phone

Student lives with _____ New address _____yes _____no

3. List **other persons, in order, who will assume responsibility for care of child if you can't be reached:**

Relationship Name Address Phone

Relationship Name Address Phone

4. **Please list other children in family:** (if additional siblings use other side)

Name Birth date Age Grade

Name Birth date Age Grade

Name Birth date Age Grade

5. _____/_____
Student's Doctor Phone

6. **STUDENT HEALTH HISTORY: Please check if your child has had any of the following:**

___ Bee Sting Allergies ____ EPI-PEN ___ Kidney Disease
___ Asthma ____ INHALER ___ Physical Handicaps
___ Chicken Pox Disease (Date)_____ ___ Diabetes ___Insulin Injections ___Insulin Pump
___ Scoliosis ___ Environmental Allergies
___ Convulsions/Seizures (Explain)_____
___ Heart Problems (Explain)_____
___ Food Allergies ___EPI-PEN order (List foods)_____
___ Allergies Meds (Other) _____
___ Other_____

Please list any medications your child is taking: _____

7. **( ) I DO ( ) I DO NOT** Give the school permission **to transport my child by ambulance** if deemed necessary
Check preference ( ) Sharon Regional Health System ( ) Horizon UPMC, Farrell

8. **CIRCLE Medications your child can receive in school when circled**
Grades K-12 Adrenalin (severe allergic reactions), Benadryl, Anti-nausea or Antacid, Cough Medicine (Robitussin)
Additional Meds for Grades 7-12 ONLY
Advil (IBP), Sudafed (decongestant), Tylenol (non-aspirin)

9. **I hereby give permission for emergency treatment, first aid** (in school or on bus) and **state mandated screenings** including vision, hearing, height, weight and scoliosis.

Parent/Guardian Signature _____ Date _____

10. **The Commonwealth of Pennsylvania requires** that students in grades K, 6, 11 receive **physical examinations and** students in grades K, 3, and 7 receive **dental exams.** Please indicate your choice below:

_____ I give permission for the school physical/dental exam to be performed by the school doctor and/or dentist free of charge.
_____ I will have my child examined by our family physician and/or dentist at my own expense.

Parent/Guardian Signature _____ Date _____