

Muhlenberg School District
HEALTH ROOM EMERGENCY INFORMATION

School _____
Grade _____
Teacher _____
Bus # _____

STUDENT NAME: _____ Sex: Female Male
Last First Middle

Birthdate: _____ Home Phone: _____ Cell Phone _____

Address: _____ Apt. _____ City _____ Zip _____

List below parent(s) or guardian child lives with:

Name: _____ Relationship to child: _____ Employer: _____ Cell number _____
Home number _____
Business number _____

Name: _____ Relationship to child: _____ Employer: _____ Cell number _____
Home number _____
Business number _____

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 _____

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.

1. _____ Phone _____ Relationship _____
Cell Phone _____
2. _____ Phone _____ Relationship _____
Cell Phone _____

Physician's Name: _____ Phone _____
Hospital Preference: _____

*In the event that my child should become seriously ill or injured while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency treatment. I understand that the Muhlenberg School District does not provide medical insurance for student injuries/illnesses but does make voluntary student insurance available. 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.

***I give permission for the Muhlenberg School District Health Services licensed school nursing staff to administer over-the-counter medications(such as medication for pain, fever, stomach upset, coughing or allergic reaction) and/or emergency medications as needed according to the Muhlenberg School District's standing physician orders. PLEASE CIRCLE ONE: Yes or No**
Medication Alleries: _____

Parent/Guardian signature _____ Date _____

PLEASE CONTACT NURSE'S OFFICE IMMEDIATELY IF ANY OF THE ABOVE INFORMATION CHANGES

OVER >

Muhlenberg School District

Does your child have a history of any of the following conditions? If so, please explain type of medical treatment:

Yes	No	
		ADD/ADHD _____
		Asthma _____
		Diabetes _____
		Migraines _____
		Food or drug allergy _____
		Bee sting allergy _____
		Seizure disorder _____
		Vision Problems _____
		Hearing Problems _____
		Other chronic or recurrent condition _____
		Emotional/Behavioral Issues _____
		Presently taking medicine _____ Name of medicine _____
		Reason for taking this medicine _____
		Has a physical condition which limits participation in physical education _____
		Has a physical condition which limits participation in classroom activities _____

Please explain _____

BROTHERS AND SISTERS IN THE SCHOOL DISTRICT:

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

Name _____ School _____ Grade _____

IF YOUR CHILD MUST RECEIVE MEDICATION WHILE IN SCHOOL, AN "AUTHORIZATION FOR MEDICATION" MUST BE COMPLETED