HASD EMERGENCY INFORMATION RECORD
2022-2023 School Year

Please PRINT information / Please notify school office if any information changes

Learner's Name _____ Birthdate _____ Grade _____
First / Middle / Last MM/DD/YY

Assigned Bus number: A.M.:_____ PM: _____ other: _____

Learner's Date of Birth _____ Homeroom Teacher:_____

Learner lives with: ☐Both parents ☐Mother ☐Father ☐Other/Name_____

Learner's Address _____Home Phone _____

Mother's Name _____Cell Phone _____

Spouse's Name _____Cell Phone _____

Address _____Phone _____

Mother's Place of Employment _____ Phone_____

Mother's e-mail address _____

Father's Name _____ Cell Phone _____

Spouse's Name _____ Cell Phone _____

Address _____ Phone_____

Father's Place of Employment _____ Phone_____

Father's e-mail address _____

List phone numbers and adults in the order in which to call in the event of an emergency, etc.:

1. #: _____ 2. #:_____ 3. #:_____

Name _____ Name _____ Name _____

List other siblings in the district name / grade:

Sibling's name:	grade:	Sibling's name:	grade:

Learner's Name _____ Birthdate _____ Grade _____
First / Middle / Last MM/DD/YY

List <u>two</u> persons with transportation who is available to pick up and care for your child if you are not available:

	Name	Home Phone	Cell/Work Phone	Relationship to child
1st				
2nd				

Name of family Physician: _____ Phone _____

Name of family Dentist: _____ Phone _____

<u>Medications taken by the student:</u>

Name of medication _____ Dose _____

_____ Dose _____

Does your child need to take any medications at school? ☐Yes ☐No ** if yes, Doctor Form is required*

Name of medication(s): _____

If emergency treatment is required, may the school authorities use their own judgment in calling an ambulance and/or sending your child to the hospital or doctor most easily accessible? ☐Yes ☐No

If no, please explain: _____

List any allergies to drugs, foods, insect bites or bee stings, or any other health conditions: (Diabetes, vision or hearing difficulties, epilepsy, asthma, heart or kidney problems, etc.)

_____

_____

Special **Health Concerns** the school should be aware of:

_____

_____

Has your child had any serious illness, accidents, broken bones, or operations in the past year?

☐Yes ☐No If yes, please list _____

The following list of non-prescription medicines and first aid materials may be given to your child for minor complaints and/or ailments while in school. The administration of these items is intended for FIRST AID ONLY and is not indiscriminately dispensed. I will be the nurse's decision in coordination with you as the parent whether or not your child receives Tylenol or Benadryl. Otherwise your child will be treated with the standing orders provided by the school district. This form will be part of your child's School Health Record and will be sent out annually in August for approval. As a parent/guardian of the child, I release Huntingdon Area School District and its employees or agents from any liability for any injuries my child may suffer as a result of this request.
Please check items the school nurse or designated school official *<u>has permission</u>* to dispense to your child.

- ☐ **Analgesic** (age/weight appropriate dose - Chewable Available)
- ☐ **Antacid** (heartburn, upset stomach, indigestion)
- ☐ **Allergy Lotion** (apply locally for poison ivy, hives, rash)
- ☐ **Cough Drops** (for coughs, sore throats, and stuffy noses)
- ☐ **Lip Balm** (dry, chapped lips)
- ☐ **Sting-Kill Swab** (to be used for bee stings/insect bites)
- ☐ **Wound Cleanser** (minor cuts/abrasions)
- ☐ **Antibiotic Ointment** (minor cuts/abrasions)

Signature of Parent or Guardian _____ Date: _____

***For your child's safety, please notify the school if any of this information changes during the school year.**

Huntingdon Area School District
2400 Cassady Avenue
Huntingdon, Pennsylvania 16652
(814) 643-4140

Southside Elementary School
10906 Station Rd.
Huntingdon, PA 16652
814-627-1100
Fax - 814-627-0301

Standing Stone Elementary
Ten 29th Street
Huntingdon, PA 16652
814-643-0771
Fax - 814-643-5947

Health Information Form

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ___/___/___ Sex:: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Mother or Legal Guardian: _____ Phone: ___-___-___ Work or Cell: ___-___-___

Name of Father or Legal Guardian: _____ Phone: ___-___-___ Work or Cell: ___-___-___

Emergency Contact: _____ Phone: ___-___-___ Work or Cell: ___-___-___

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, seasonal)			Diabetes		
Arthritis			Head Injury, Concussions		
Asthma or Breathing Problems			Hearing Problem or Deafness		
Attention-Deficit/Hyperactivity Disorder			Heart Problems		
Behavioral problems			Lead Poisoning		
Developmental problems			Muscle Problems		
Bladder Problems			Seizures		
Bleeding Problems			Sickle Cell Disease (Not Trait)		
Bowel Problem			Speech Problem		
Cerebral Palsy			Spinal Injury		
Cystic Fibrosis			Surgery		
Dental Problems			Vision Problems		

Describe any other important health related information about your child (for example: feeding tube, hospitalizations, oxygen support, hearing aid, etc.): _____

_____

List all Prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/Primary Care Provider			
Specialist			
Dentist			
Case Worker (If Applicable)			

I, _____ (do__) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this for. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school.*** *When information is released from your child's records, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____ Date: ___/___/___