DOWNINGTOWN AREA SCHOOL DISTRICT STUDENT EMERGENCY CARD Date _____

STUDENT'S NAME: **HOME PHONE ( )**
Last First M.I.
BIRTHDATE : _____GRADE: _____ HOME ROOM NUMBER/TEACHER _____
ADDRESS: _____CITY: _____ZIP :_____
RESIDES WITH _____ who is a parent/guardian _____

CALL THIS PARENT/Guardian FIRST:
NAME _____
HOME PHONE ( ) _____
WORK PHONE ( ) _____
CELL PHONE/PAGER ( ) _____

CALL THIS PARENT/Guardian SECOND:
NAME _____
HOME PHONE ( ) _____
WORK PHONE ( ) _____
CELL PHONE/PAGER ( ) _____

Please provide emergency contacts below, if parent or guardian cannot be reached:

NAME:_____ or NAME _____
Phone: ( ) _____ Phone: ( ) _____

Physician _____Phone:( ) _____ Dentist; _____ Phone: ( ) _____

MEDICAL HISTORY:_ If your child is ALLERGIC to BEE STINGS, MEDICATIONS, FOODS, or ANY OTHER SUBSTANCE please list the substance and the treatment: _____
_____
My child needs an Epi-pen for his/her Allergic reaction: (Please Circle) Yes No
Is your child taking daily medication? What & Why? _____
Please list conditions that require special attention (i.e. Asthma, ADD, ADHD, Heart, Seizures, Diabetes or other Chronic Conditions) _____
_____

My child wears: (Please Circle) Glasses / Contacts / Hearing Aids / Other Devices

I GIVE MY PERMISSION TO ADMINISTER:

Medication Name	(PLEASE CIRCLE YES OR NO BELOW)	
Tylenol/Generic Tylenol	Yes	No
Ibuprofen/Generic Ibuprofen	Yes	No
Benadryl/Generic Benadryl	Yes	No
Maalox/Tums/Generic Antacid	Yes	No

OVER THE COUNTER MEDICATION (not on the approved list by school physician) must be dispensed in the health room and accompanied by a note from the parent/guardian and health care provider. The medication must be in the original labeled package. All over the counter medications will be dispensed according to the recommended dosage on the package only.

PRESCRIPTION MEDICATION must be dispensed in the health room with a note from the health care provider and a note from the parent/guardian. The medication must be in the original pharmacy bottle. The label must include the child's name, date, drug name, dose and direction for use.

I hereby give Downingtown Area School District permission to release/obtain information regarding immunizations, diagnosis and treatment of health concerns.

If school personnel are unable to contact you or any of the people listed on this card, including the doctor, they may make whatever arrangements seem necessary in an emergency at no expense to the school district

SIGNATURE OF PARENT/GUARDIAN _____Date _____
Please list the names and school of siblings attending Downingtown Area School District