Please complete both sides of this form.

Bellefonte Area Schools Emergency Health Form

Student name_____ **Age**_____ **Grade**_____
Homeroom_____
Address _____ **Home Phone** _____
Father's Name _____ **Work #**_____ **Cell #** _____
Mother's Name _____**Work #** _____**Cell #** _____

Email Address where you would like to receive Health Information _____

In Case of Emergency: If parents are not available: (*Do not list neighbors or Relatives if they have not consented to help. List someone who is available and has transportation).*

Friend or Relative: _____ **Phone #** _____
Does your child have a reaction to insect bites? (other than swelling) Yes_____ **No** _____
What measures do you take? _____

Does your child have Food or Medication Allergies?
_____

Medical Problems you would like the school to know about? _____
_____
_____
Daily Medications:_____
_____

IN CASE OF AN EMERGENCY REQUIRING IMMEDIATE MEDICAL ATTENTION, I GIVE MY PERMISSION TO TRANSPORT THIS STUDENT, BY AMBULANCE IF NECESSARY, TO THE NEAREST HOSPITAL. I ASSUME RESPONSIBILITY FOR PAYMENT.

If I am unavailable for purposes of providing parental consent, I hereby authorize the physician(s) and staff in the emergency/outpatient department to provide such hospital care that includes routine diagnostic procedures and medical treatment as necessary to my minor son/daughter. I understand that the consent and authorization herein granted does not include major surgical procedures. It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail. The recommendation of the parent as indicated above will be respected if at all possible.

_____
Child's Full Name

_____ **Date** _____
Signature of Parent/Guardian

Your signature here gives permission for this medical information to be shared with faculty, staff, and transportation personnel who may come in contact with your child. This information will only be given out on a need to know basis.

Please complete both sides of this form.

Bellefonte Area School District
Elementary OTC Permission Form

Parent request for administration of over the counter medications while at school

The certified school nurse or other licensed healthcare professional may administer the following over the counter medications to students while at school. They will not be administered without this form on file in the health room. This consent covers occasional use only, and these medications will be given only at the nurse's discretion. Any student who requires any of the listed medications daily, or on a regular basis, will need a medication consent form filled out by the student's physician. This form must be completed yearly. This form is good for elementary school students.

The meds on stock are as follows, place initials in the box next to the item you give permission for your student to have:

- ❑ Antibiotic or first aid ointment as needed
- ❑ Calamine lotion or Calagel: apply to skin for localized itching
- ❑ Hydrocortisone cream as needed
- ❑ Menthol cough/throat drops as needed
- ❑ Oral analgesic gel to gums every 4 hours as needed
- ❑ Lubricating eye drops 2 drops every 4 hours as needed

My child may take the medication specified above. The school nurse or other licensed health care professional has my permission to dispense this medication to my child. As parents/guardians of the child named below, I/we release the Bellefonte Area School District and its employees or agents for any and all liability for any injuries my child may suffer as a result of this request.

_____ _____
Student's name Parent signature

Date_____ Print parent name_____