Seneca Valley School District Health and Emergency Form

for specific extracurricular activities and overnight trips

Student's Name: ________________________________ Grade: ______ Date of Birth: _________
Last First M.I.

Home Address: _____________________________ City: ________________ State: ____ Zip: ________

Please check all that apply:

Marching Band _____ Pom Pons _____ Color Guard _____ Symphonic Band_____ Wind Ensemble_____

Jazz I _____ Jazz II _____ Freshman Band _____

What Instrument? ________________________

Mother/Guardian **Father/Guardian**

Name ____

Home Phone ____

Work Phone____

Cell Phone____

Emergency Contacts: List individuals who are willing to transport your student, in order of preference if you cannot be reached.

1) Name ____________________________ Phone ____________ Relationship_________________

2) Name ____________________________ Phone ____________ Relationship_________________

Health Insurance Company: ____

Group Number: ____________________________ ID Number: ________________________________

Student's Physician: __________________________ Phone: __________________________________

Student's Dentist: ____________________________ Phone: __________________________________

In case of emergency requiring immediate medical treatment, I give permission for the transport of this student to the nearest medical facility. If an ambulance is necessary, the closest available service will be called. If possible, an attempt will be made to contact the parent/guardian prior to transporting an injured or ill student. Payment for ambulance service to transport the student will not be the responsibility of Seneca Valley School District or associated booster organizations.

We are required by law to maintain the privacy of your health information. We may use or disclose your health information for purposes of treatment only.

____ ____________________________
Signature of Parent/Guardian Date

Please sign all areas requiring Parent/Guardian and Student Signature on both sides of the form.

Medical History

Please indicate below any of the following conditions that are applicable to your child. If none apply, please indicate so at the bottom of this section.

1. Life Threatening Allergies: ____Yes ___No To What: ______________________________________
   If Yes, does your child have an Epi Pen prescribed by the physician? ____________________________

2. Environmental/food allergies or intolerances: ____
   _______________________________________ Medications for these: ___________________________

3. Asthma ____________ Triggered by: ____
   If Yes, does your child carry an inhaler? Type: ____

4. Seizure Disorders ____________ Date of last seizure _______________Medications ___________________

5. Diabetes _______ Insulin dependent or other medications: ____
   Usual Glucometer readings: AM __________ Before meals __________ Bedtime __________

6. Chronic joint/muscle problems (please specify where, symptoms and usual treatment): ___________________
   _____________________________________ Medication for this: _______________________________

7. Abnormal bleeding problems:
   Menstrual problems _________ Describe ______________________ Medications _________________

8. Has your child been hospitalized in the past 6 months? _______ If Yes, please explain: __________________
   ____

9. Social/emotional difficulties that effect daily behavior: ________ If Yes, please explain: _________________
   ____

10. Other conditions or additional information you would like to share: _________________________________

NONE OF THE ABOVE ________

Date of Last Tetanus Shot: ___________________________________

Medications

I agree that all prescription and non- prescription medications that will be in my student's possession are listed below:

Medications	Dose and Frequency	Reason for Administration
1)		
2)		
3)		

The chaperones carry a limited supply of the non-prescription medications listed below. I give permission for my student to receive, if necessary, the following medication according to recommended product dose.

Please note with a check mark those medications for which you give permission for your child to receive.

_______ Tylenol _______ Dramamine _______ Sudafed _______ Tums
_______ Ibuprofen _______ Robitusin DM _______ Benadryl _______ Immodium

I give permission for my student to self administer these prescription and/or non-prescription medications. I, and the student, understand that distribution of any medication to others is in violation of the Seneca Valley School District medication policy and will cause the student disciplinary consequences.

I do hear by release, discharge, and hold harmless the Seneca Valley School District, its agents or employees, and the booster organization, from any and all liability, and claim whatsoever for the administration of the above medication(s) to my child/ward should they develop an allergic or other reaction from medication.

____________________________ __________ ____________________________ __________
Signature of Parent/Guardian Date Signature of Student Date