Barbara Lecker, R.N., Senior High School, (724) 695-5256
Deborah Elicker, R.N., Middle School - (724) 695-5234

Beth Bauer, R.N., Donaldson Elementary (724) 213-1015
Becky Schroeder, R.N., Wilson Elementary, (724) 695-5275
Mary Beth Hill, R.N., McKee Elementary, (724) 695-5265

WEST ALLEGHENY SCHOOL DISTRICT

EMERGENCY/MEDICAL AUTHORIZATION

PLEASE COMPLETE THE FOLLOWING EMERGENY/MEDICAL INFORMATION
THIS FORM MUST BE RETURNED TO THE NURSE IN ORDER TO AVOID DELAY AT THE TIME OF AN EMERGENCY
PLEASE BE SURE TO ENTER AREA CODES ALONG WITH TELEPHONE NUMBERS

STUDENT I.D.#______________________ TEACHER______________________

NAME ______________________________________ GRADE ______________________

ADDRESS ______________________________________ BIRTH DATE ______________________

______________________________________ SOCIAL SECURITY______________________

______________________________________ LOCKER#______________________

______________________________________ HOME PHONE (   ) ______________________

FEMALE/PARENT(Guardian):______________________________ PHONE# (   ) ______________________

PLACE OF WORK:______________________________ WORK# (   ) ______________________

MALE/PARENT(Guardian):______________________________ PHONE# (   ) ______________________

PLACE OF WORK:______________________________ WORK# (   ) ______________________

DOCTOR:______________________________ PHONE# (   ) ______________________

List the names of neighbors or nearby relatives who will take temporary care of your child if you cannot be reached

EMERG. CONTACT 1:______________________________ PHONE # (   ) ______________________

EMERG. CONTACT 2:______________________________ PHONE # (   ) ______________________

BUS # AND LOCATION______________________________

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hearby authorize the school to call the physical indicated above and to follow the instructions. If it impossible to contact this physician, the school may make whatever arrangements are necessary.
I hereby agree to hold the West Allegheny School District and its representative harmless for exercising its judgment in authorizing such emergency medical treatment.

Signature of Parent or guardian:______________________________ Date______________

In order to update student medical records, please complete the following questions and return to the school health office. If you wish not to share this information with faculty, please inform the nurse's office. Thank you for your cooperation.

______ Allergies ______________________________

Allergic Response ______________________________

_______Arthritis	_______Asthma	_______Attention Deficit (Hyperactivity Disorder)
_______Autism	_______Blood Disorder	_______Cardiac Disorder
_______Cerebral Palsy	_______Chicken Pox	_______Crohn's Disease
_______Color Blind	_______Diabetes	_______Down's Syndrome
_______Eating Disorder	_______Eczema	_______Gastric Ulcer
_______Headaches	_______Hearing Impaired	_______Heart Murmur
_______Hemophilia	_______Orthopedic Disorder	_______Osgoode Slauter
_______Prosthetic Devices	_______Scoliosis	_______Seizure Disorder
_______Spina Bifida	_______Thyroid Disorder	_______Ulcerative Colitis
_______Urinary Tract Disorder	_______Vision Impairment	

Please list medication your child takes on a daily bases. If so, please answer the following:

Name of Medication:

Dosage:______________________ Takes in school _______Yes _________ No

Reason for medication:______________________________

PLEASE NOTE: If any medication is required to be given during the school day, a signed permission form must be presented by the physician and the parent. Medication **will not** be given without the above. This includes Tylenol, aspirin and over the counter drugs.

Please list booster shot dates of the following immunizations:

DPT ______________ POLIO______________ MMR #1______________
MMR #2______________

Hepatitis B #1__________ #2 __________ #3 __________

Date of last TB Tine Test ______________ Result ______________

Please list dates of any serious accidents or operations:

__________ ______________________________

__________ ______________________________

Please list any health conditions or limitations your child has:______________________________

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