Barbara Lecker, R.N.
Senior High School, (724) 695-5256
Deborah Elicker, R.N.
Middle School, (724) 695-5234
Becky Schroeder, R.N.
Wilson Elementary, (724) 695-5275

Beth Bauer, R.N.
Donaldson Elementary, (724) 213-1015
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______________________

____ HOME PHONE ______(______)____________

FEMALE/PARENT(Guardian):____ CELL# (______)________________

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 hereby authorize the school to call the physician 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________________

Emerinfo.Doc. (2/98)

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 ________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 the date of any immunizations that have been given in the past 12 months:

DPT ______________________ POLIO______________________ MMR #1______________________ MMR #2____________________________

Hepatitis B #1_____________ #2 _____________ #3 _____________ Chicken Pox (date of disease) ________________________________

Date of last TB Tine Test ____________________________ Result _________________________ Chicken Pox (date of immunization) ___________________

Please list dates of any serious accidents or operations:

___________ ____

___________ ____

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

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