HEALTH ROOM EMERGENCY INFORMATION
COATESVILLE AREA SCHOOL DISTRICT

Last Name________________________ First Name______________________ Male / Female Birthdate_____________ Grade/Room_______

____

Home Address City Zip Code Home Phone

Resides with: Mother ____ Father ____ Both ____ Guardian ____
Mother's Name ______________________________________
Place of Employment __________________________________
Work # __________________________ Extension/Dept: _________
Home ph #_____________________Cell # ____________________
Email ____

Guardian's Name: ____
Father's Name ____
Place of Employment ____
Work # _________________________ Extension/Dept: __________
Home ph #___________________ Cell# _______________________
Email ____

Which person/number should we try first? ____

IF PARENT/GUARDIAN CANNOT BE REACHED, CONTACT:

1. ____
   Name Relationship to student Day Phone
2. ____
   Name Relationship to student Day Phone

MEDICAL HISTORY

Is your child allergic to bee/insect stings? No/ Yes Reaction and treatment: ____
Is your child allergic to anything else? No/Yes What and treatment: ____
Is your child taking any medication **at home or school**? No/Yes What/Why: ____
Please list any current medical conditions/concerns (asthma, diabetes, seizures, lyme disease, heart problems, ADD, etc.): ______________
____
Doctor __________________________ Phone ___________________ Dentist ________________________ Phone ___________________
Does your child wear glasses? _____ Contact Lenses? ______ Hearing aides? _____ Other/Name ___________________________________

FAMILY INFORMATION

Names of brothers/sisters attending Coatesville Area School District and school they attend:

Name ____ School ____
____ ____
____ ____

INSURANCE INFORMATION

Insurance Company ____ Policy Number ______________________________

Dental Insurance __________ Yes __________ No Vision Insurance __________ Yes __________ No

I GIVE MY PERMISSION FOR MY CHILD TO RECEIVE THE FOLLOWING MEDICATIONS:

Acetaminophen (Generic Tylenol)	Yes __________	No __________
Ibuprofen (Generic Advil/Motrin)	Yes __________	No __________
Diphenhydramine (Generic Benadryl)	Yes __________	No __________
Essence of Peppermint (for stomach aches)	Yes __________	No __________
Tums/Maalox (for stomach aches)	Yes __________	No __________

Any Special Instruction: ____
____

I give my permission for my child to receive the ABOVE medications provided by the CASD and dispensed by the School Nurse/Health Assistant.

I also give my permission for the information on this card to be shared with appropriate school personnel. I authorize the Coatesville Area School District to release to and obtain information from the family health care provider/dentist (immunizations, diagnoses, treatments, exams).

____ ________________________

Signature of parent/legal guardian Date

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