

**MIDLAND ELEMENTARY MIDDLE SCHOOL
EMERGENCY CARE CARD**

Student _____ Circle M or F Grade _____ Homeroom _____
(Last) (First) (Middle)

Address _____

Circle Ethnic Code: African-American American Indian Asian Hispanic Multi-Racial White Birth Date _____

Circle who your child lives with. Mother Father Stepmother Stepfather Grandparents
Other _____

Mother's Name _____ Home # _____ Cell # _____

Mother's Employer _____ Phone _____ E-mail _____

Father's Name _____ Home # _____ Cell # _____

Father's Employer _____ Phone _____ E-mail _____

Names and grades of brothers and sisters _____

The MBSD has partnered Intouch Notification System to provide mass communication to parents for general information, weather, and emergencies. Please complete how you wish to receive emergency information

Cell/Home Phone _____ Can you receive a text from this number? Yes or No

Email 1 _____

Please list only **Parent Substitutes** who school officials can contact regarding your child's care in the event a parent cannot be located if there is an illness or emergency & photo ID is required. *PLEASE NOTE: If your child has a dismissal or transportation change you will need to send a separate note with them to school. We will not accept phone calls for dismissal changes even if you use a parent substitute listed below. The emergency card parent substitute does not constitute authorization for transportation or dismissal changes.*

Name _____ Relation _____

Phone _____ Address _____

Name _____ Relation _____

Phone _____ Address _____

Name _____ Relation _____

Phone _____ Address _____

List below anyone who is **NOT PERMITTED** to visit/pick up your child from school:

Name _____ Name _____

HEALTH INFORMATION

List any **health conditions** that your child has: _____

List any **medications** that your child takes:

At home _____

At School _____

List any **allergies** that your child has and what treatment is needed for reactions.

Environmental allergies _____

Food Allergies _____

Insect/Bee Allergies _____

_____ YES. _____ NO Has your child had the chicken pox disease? If yes, at what age? _____

Do you give permission for your child to receive these *Over the Counter* medications? MBSD has "standing orders" for these medications. Generic forms may be used. Circle YES or NO for each item.

Advil/Ibuprophen	YES or NO	Benadryl (for allergic symptoms)	YES or NO	Cough Drops	YES or NO
Anbesol/Oraol	YES or NO	Tylenol/acetaminophen	YES or NO	TUMS	YES or NO
Antibiotic Ointment	YES or NO	Insect sting/burn gel	YES or NO		

Any student receiving Advil and/or Tylenol via standing order for **3 consecutive days or 10 doses in a school year will automatically have the standing order discontinued.** To continue Acetaminophen and/or Ibuprofen therapy a prescription must be received from the student's family physician requesting the medication be continued and for what length of time.

Family Physician _____ Phone _____

Office Address _____

_____ YES. _____ NO Does your child have medical health insurance? If not, information will be sent home concerning the CHIPS program.

_____ YES. _____ NO In the event of a radioactive emergency, do you want your child to receive **potassium iodide** if instructed by public health officials?

_____ YES. _____ NO **Do you give your permission for your child to be photographed or video graphed for school publications and school publicity purposes?**

The following **screenings** are mandated by Pennsylvania School Code. Please notify the school nurse in writing if you do not wish to have the screenings done at school.

Vision: All grades Hearing: Kdg through grade 3 plus grades 7 and 11 and all special ed students

Height and Weight: All grades Scoliosis: Grades 6 & 7

IF SCHOOL REPRESENTATIVES ARE UNABLE TO CONTACT PARENTS IN THE EVENT OF AN EMERGENCY, THE SCHOOL WILL HAVE YOUR STUDENT TRANSPORTED BY AMBULANCE SERVICE

_____ YES. _____ NO I give permission for my child's health information to be shared with school staff and emergency care personnel on a need to know basis.

_____ YES _____ NO I give my permission for the school nurse to communicate with the physician listed above regarding any pertinent medical issues relating to my child.

Parent/Guardian Signature _____ Date _____