Bethel Park School District
Emergency Information Card

PLEASE PRINT CLEARLY Information and Authorization for School Year: **2008-2009**

Student's Name _____ Birthdate _____ Grade/HR _____
Last First Middle Initial

Address_____ Home Phone#_____

Father's Name _____ Phones: (H) _____ (C) _____

(Father's W#) _____ Father's E-Mail _____

Mother's Name_____ Phones: (H) _____ (C) _____

(Mother's W#) _____ Mother's E-Mail _____

Names, ages, and relationship of individuals who live with the student: _____

_____

Emergency Contacts: Please list names of relatives or friends who may be contacted in the event of illnesss, injury or other emergency, and who is authorized to pick up your child in these instances.

Name_____ Relationship_____ Phone#_____ Cell_____

Name_____ Relationship_____ Phone#_____ Cell_____

Name_____ Relationship_____ Phone#_____ Cell_____

----------Complete and SIGN Reverse Side----------

EMERGENCY INFORMATION
In the event of any emergency, the EMS will transport the student to a hospital or specialty facility deemed necessary.

For your child's safety and well being, it is essential that the school nurse and principal be informed of any existing medical or emotional conditions, any changes in the condition(s), or a newly diagnosed condition (such as asthma, diabetes, seizures, attention deficit disorder, depression, bleeding disorders, heart disease, etc.) and the treatment or medication that the student needs.

It is also necessary to inform the school nurse of **any medication that the student takes at home and/or at school.** For the safety of all students, **medication** (prescription or over the counter) **may not be carried by students** except for inhalers and EpiPens, and only when an appropriate written order from the physician has been filed with the school nurse.

Name of Health Care Provider _____ Phone_____

Name of Dentist _____ Phone_____

List medical/emotional conditions your child has: _____

List allergies your child has: _____Treatment for allergies: _____

List all medications your child regularly takes: _____

Note: If your child does not have Health, Dental, or Vision Insurance, the School Nurse can provide you with information regarding free or low cost coverage. Please check the appropriate boxes if you wish to receive information regarding any of the following:

_____Health Insurance _____ Dental Insurance _____ Vision Insurance

Parent/Guardian's Signature _____ Date_____

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