MED 1

EMERGENCY INFORMATION

DATE: _______________

STUDENT'S NAME ____ DATE OF BIRTH ______________________
(LAST) (FIRST) (MIDDLE)

ADDRESS ____ PRIMARY PHONE ________________
(STREET) (CITY) (ZIP CODE)

S.S # _______________________ MEDICARE # ___________________________ MEDICAID # ____________________________

TRANSPORT PROVIDER/PH # ____ CELL # ____________________

	NAME	ADDRESS	PHONE	EMPLOYER/PHONE
Mother/Responsible Party				
Father/Responsible Party				
Provider Name/Contact (if applicable)				
Court Appointed Guardian				

EMERGENCY BACKUPS: **Identify two neighbors or relatives with a <u>local</u> telephone and available transportation who have agreed to relay a message and/or pick up the student in an emergency:**

1) ____

2) ____
NAME ADDRESS PHONE

****

HEALTH INFORMATION

<u>STUDENT'S</u>: HEIGHT: _______Feet _______Inches WEIGHT: ________ lbs. AGE: ________Yrs.

Last Physical Exam: ______________ Last Vision Exam: _______________ Last Dental Exam: _____________
(DATE) (DATE) (DATE)

Immunizations Last Year: Type/Date: ___________________________________ Last Tetanus Date: _____________

HEALTH/MEDICAL PROBLEMS	PHYSICAL LIMITATIONS	DIET INFORMATION	ALLERGIES

LIST ALL CURRENT MEDICATIONS THE STUDENT TAKES DAILY, WHETHER AT HOME/SCHOOL. IF NO MEDICATION IS TAKEN, WRITE <u>NONE</u>

NAME AND DOSE OF MEDICATION	NAME AND DOSE OF MEDICATION	NAME AND DOSE OF MEDICATION

<u>NOTE</u>: IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO INFORM THE SCHOOL NURSE IMMEDIATELY OF CHANGES IN THIS INFORMATION. SERVICES MAY BE INTERRUPTED IF CURRENT EMERGENCY INFORMATION IS NOT PROVIDED.

SEIZURE INFORMATION

Does the student have seizures? ☐ Yes ☐ No if yes, date of last seizure ______________________________

How long does a seizure last? ___________ (seconds/minutes) how often do they occur? ________________________

BEFORE, DURING, OR AFTER A SEIZURE, DO ANY OF THE FOLLOWING OCCUR? (Please check)

☐ Cries Out ☐ Rolls Eyes ☐ Urinates ☐ Twitching ☐ Becomes Confused ☐ Becomes Rigid

☐ Falls down ☐ Skin Color Changes ☐ Becomes Unconscious ☐ Body Jerks ☐ Vomits

When the student is dropped off at home from our transportation, does there need to be someone at home to meet the student? **YES** ☐ **NO** ☐ If yes, identifies the person(s) to be present at Home and meet the bus to assist the student. **NOTE:** Transportation staff will not release the student to a person(s) not listed.

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FIRST AID

Do you consent to the program staff administering first aid in case of illness or injury to the student during the program day? ☐ Yes ☐ No

If yes, I agree to hold harmless the Stark County Board of Developmental Disabilities and its 'employees for any injury resulting from administration of such first aid.

_________________________________ ____________

Parent/Guardian Signature Date

IMPORTANT - YOU MUST COMPLETE AND SIGN EITHER PART I OR PART II BELOW - IMPORTANT

Part I **GRANT OF CONSENT**

In the event reasonable attempts to contact me at ______________ (Phone number) or to contact _________________________ (Other parent/guardian) at _______________ (Phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed Necessary by Dr. ________________ (Physician) ____ (Address) _________________ (Phone) or Dr. ________________________ (Dentist) _________________________________ (Address) ___________________ (Phone) or in the event These are not available, by any other licensed physician or dentist, and (2) the transfer of the student to

__________________________ (Preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_________________________________ ____________

Parent/Guardian Signature Date

-OR-

Part II **REFUSE TO CONSENT**

I DO NOT give my consent for emergency medical treatment of this student. In the event of illness or injury requiring treatment, I wish program authorities to TAKE NO ACTION or to:

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_________________________________ ____________

Parent/Guardian Signature Date