Austintown Local School District Emergency Medical Form (School Year 2018-2019) *For School Use Only:*

The State of Ohio requires the Emergency Medical Form be updated annually *Homeroom #_____*

Student Information		
Student Name:	❑ **Male** ❑ **Female** **Date of Birth:**	**Grade:**
Student Address:	**City/State:**	**Zip**

Residential Parent/Guardian Information (please answer Questions A, B, & C)	
A. Student lives with (please X one): ___Both Parents ___Mother Only ___Father Only ___Other:_____ Active Military: __Yes __No, If yes,: __Mother __Father ___Both Other:_____	**B. Are the student's parents/guardians (please X one):** ___Married ___Divorced ___Separated ___Never Married ___Otherwise living separately, please explain:
C. Who has legal custody for child(ren) (please X one): ___Both Parents ___Mother Only ___Father Only ___Shared ___Other:_____	**If Separated or Divorced, Custody Papers are Required for Student File.** **For Shared Custody, provide addresses of both parents below.**

Legal Parent/Guardian Information	***Legal Parent/Guardian Information***
Name:	**Name:**
Cell Number:	**Cell Number:**
Home Number:	**Home Number:**
Primary Email:	**Primary Email:**
Relationship to Student: Mother / Stepmother / Foster Mother / Grandmother / Father / Stepfather / Foster Father / Grandfather / Guardian **(Please circle one)**	**Relationship to Student:** Mother / Stepmother / Foster Mother / Grandmother / Father / Stepfather / Foster Father / Grandfather / Guardian **(Please circle one)**
Is your address the same as the student? _____Yes _____No **If No, list your current Address, City, State , Zip:**	**Is your address the same as the student?** _____Yes _____No **If No, list your current Address, City, State , Zip:**

Emergency/Alternate Contacts

In the event you are unable to contact me at the above numbers, you have my permission to contact the following alternates. They have my permission to receive health care information regarding my child and can take my child home during school hours if needed.

Contact 1 (other than Parent/Guardian)	***Contact 2 (other than Parent/Guardian)***
Name:	**Name:**
Relationship:	**Relationship:**
Best Contact Number:	**Best Contact Number:**
Contact 3 (other than Parent/Guardian)	***Contact 4 (other than Parent/Guardian)***
Name:	**Name:**
Relationship:	**Relationship:**
Best Contact Number:	**Best Contact Number:**

Emergency Authorization

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by named doctor below, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Consent Given: _____Yes (if Yes, please list "Medical Contacts" below) _____No (if No, please give "Content Refusal Instructions" below)		
Doctor Name:	**Doctor Phone:**	
Dentist Name:	**Dentist Phone:**	
Hospital Name:	**Hospital Phone:**	**Branch:**
Consent Refusal Instructions:		

Parent/Guardian Signature: _____Date: _____ ***TURN OVER***

Austintown Local School District Health Information (School Year 2018-2019)

Student Name:_____ **Grade:**_____

Your child's health and education are very important to us. The information below will be used to facilitate your child's learning. Informing and educating staff about your child's needs will help promote his/her wellbeing. Confidentiality will be maintained and the information will be shared with those responsible for meeting the child's health care needs.

1. Peanut Allergy?	**__Yes __No**	**Describe Reaction:**_____ _____ **Difficult breathing? __Yes __No Emergency Medication? __Yes __No** **Do you eliminate all peanut-containing food?__Yes __No**
2. Other Food Allergy?	**__Yes __No**	**Food?**_____ **Describe Reaction:**_____ **Difficult Breathing? __Yes __No Emergency Medication? __Yes __No**
3. Allergy?	**__Yes __No**	**Medications, seasonal or environmental? List:**_____ _____ **Has allergy required emergency care in the past? __Yes __No** **Comments:**_____
4. Sting Allergy?	**__Yes __No**	**Bee/insect?** _____ **Describe reaction:**_____ **Difficult breathing? __Yes __No Emergency Medication? __Yes __No**
5. Diabetes?	**__Yes __No**	**DIABETES MANAGEMENT PLAN FROM DR AND SUPPLIES MUST BE IN CLINIC BY THE FIRST DAY OF SCHOOL.**
6. Asthma?	**__Yes __No**	**Inhaler? __Yes __No, Kept in Clinic? __Yes __No, Self-Carry? __Yes__No**
7. Epilepsy/seizures?	**__Yes __No**	**Emergency medication?__Yes __No**
8. Heart Condition	**__Yes __No**	**Describe:**_____ **Activity restrictions?__Yes __No Describe:**_____ _____
9. Other? (any other health information you would like us to know about your child)	**__Yes __No**	**Describe:**_____ _____ _____

Please check ALL that apply regarding your child's vision and hearing:

Eyes: **___Lazy Eye ___Crossed ___Difficulty Seeing ___Glasses ___Contacts**

Ears: **___Frequent Infections ___Tubes ___Hearing Difficulty ___Hearing Aid for: ___Right Ear ___Left Ear**

***Vision Screenings will be performed in grades K,1,3,5,7,9**

***Hearing Screenings will be performed in grades K,1,3,5,9,11**

Daily Medications Taken by Student

Requirements for Medications to be administered at school:

A. It is strongly recommended to parents, with their physician's counsel, that the medication schedule should be adjusted to avoid administering medication during school hours.

B. If this is not possible, then the Medication Authorization Form must be filed with the respective building health clinic before the student will be allowed to take medication during school hours. This written and signed request form is to be submitted each school year.

Name of Medication:	Reason for Taking:	Taken where?
		Home and/or School
		Home and/or School
		Home and/or School

Does your student require special health care? __Yes __No If yes, please explain:_____

Circle Yes or No for the following questions:

1. The Austintown Local School District Nurses (or other trained personnel) may administer acetaminophen (Tylenol) for orthodontics, headaches, and menstrual cramps during this school year with signed parental permission, up to 3 doses then medicine needs to be provided from home (This applies to grades 4-12). **YES or NO**
2. The Austintown Local School District Nurses (or other trained personnel) may administer TUMS for complaints of heartburn, sour stomach, or acid indigestion with signed parental permission, up to 3 doses then medicine needs to be provided from home. (This applies to grades 4-12). **YES or NO**
3. The Austintown Local School District Nurses (or other trained personnel) may administer Benadryl for emergency reaction only, during this school year with signed parental permission, do you give consent? **YES or NO**
4. BMI Screening (Body Mass Index screening for Grades Kg, 3rd, 5th, & 9th). Part of Healthy Choices for Healthy Children Act. Do you give consent to have this screening done? **YES or NO**
5. May your 5th Grade student attend the boy's or girl's puberty education program presented by a District Registered Nurse? **YES or NO**

Parent/Guardian Signature: _____ **Date:** _____