

Health Room Emergency Card

Bus No. _____ Teacher: _____ Student No. _____

Student: _____ Birthdate: _____ Grade: _____
(Last Name) (First Name)

Address: _____ Ph: _____
(Street Address, City, and Zip Code) (circle if unlisted)

Please Leave Blank / For Nurse's Use Only

Number of brothers/sisters in Millcreek schools: _____ Grades: _____

Child lives with (circle one): Both Parents Mother Father Other: _____

Father _____
First & Last Name Where Employed Phone Cell Phone

Mother _____
First & Last Name Where Employed Phone Cell Phone

If Parent/Guardian Cannot Be Reached, Call:

1. _____
First & Last Name Relationship Phone Cell Phone

2. _____
First & Last Name Relationship Phone Cell Phone

Doctor: _____ Ph: _____

(OVER)

Please describe any identifying birthmarks, scars, or distinguishing features your child may have:

Medical condition(s)/Allergies/Physical Restrictions:
Medications:

Permission to share above info with staff/faculty: Yes No
Requires medication be administered during school hours (including inhaler)? Yes No
Note: If yes, please contact the school nurse

In the event that I cannot be reached at the number on the reverse side, I give my permission for the school administration and/or their representative authority to have my child treated and cared for.

(Date) (Signature) (Hospital Preferred)

Does your child have health insurance coverage? Yes No
If no, healthcare may be available through CARING PROGRAM. Call toll-free (800) 543-7105

In accordance with PA School Code, a physical examination must be completed on **entry** into school, and in grades **6 & 11**. I wish this examination to be done by the School Physician at no cost to me.

(Date) (Signature)

(OVER)
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