

OTTER VALLEY EMERGENCY INFORMATION CARD

Grade _____ Sex: M ___ F___
School Year _____ - _____

PLEASE PRINT (FRONT AND BACK)

• **Student's Name** _____ Birth Date _____
Last First

Student's 911-Street Address _____ Town _____

Mailing Address (if different) _____ Town _____

• **Student Lives with:** Both Parents ___ Mother only ___ Father only ___ Legal Guardian ___

• **If separated or divorced, who has legal/physical custody?** Mother ___ Father ___ Shared ___

• **Mother's Name(or legal guardian)** _____ Home Phone _____

Address (if different than student's) _____ Cell Phone _____

Name of Workplace _____ Work Phone _____ Extension # _____

E-Mail Address _____

• **Father's Name(or legal guardian)** _____ Home Phone _____

Address (if different than student's) _____ Cell Phone _____

Name of Workplace _____ Work Phone _____ Extension # _____

E-Mail Address _____

• Siblings (first and last names and ages) _____

**Is there anyone, documented by a court order that we should not release your child to? _____

**NOTE: Without a Court Order on file at school, the school does not have the legal authority to refuse a natural parent the right to pick up his / her child.

• **List two neighbors/ nearby relatives to assume care and provide transportation for your child if you cannot be reached.**

Name _____ Relationship _____ Name _____ Relationship _____

Address _____ Address _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to contact me, I hereby authorize the school to call the physician/dentist indicated above, and follow his/her instructions. If it is impossible to contact this physician/dentist in a timely manner, the school may take whatever actions seem necessary given the nature of the incident.

Signature _____

Date _____

OTTER VALLEY MEDICAL QUESTIONNAIRE

Please check any of the following conditions which your child has or has had in the past:

ADD/ADHD _____	Hearing problems/hearing aids _____
Anxiety/Depression _____	Asthma/Respiratory Disease _____
Bladder/kidney problems _____	Bowel problems _____
Diabetes _____	Epilepsy _____
Frequent headaches _____	Frequent stomachaches _____
Acid Reflux _____	Head injury/concussion _____
Heart conditions/murmur _____	Tubes in ears _____
Vision problems _____	

Other health problems or further explanation of the above: _____

Medications taken on a regular basis: (including those taken at home)

Name	Dose	Time of Day

Will your child need to take medication or an inhaler while at school? Yes ___ No ___

If yes, please list: _____
 (Prescription Medications, including inhalers, given at school require a signed physician order)

Allergies: (including food, medication, environmental) **Yes** _____ **None Known** _____

If yes, (Please list and explain reaction type, ex: stuffy nose, hives, anaphylaxis, etc.)

If Severe Allergy, is there an Epi-pen prescribed? Yes ___ No ___

Parental Authorization:

Your child may present to the nurse's office with a mild illness or injury that may require the nurse to administer an over the counter (OTC) medication for treatment of symptoms. Please sign and fill out the section below indicating what we may give your child.

(Please circle)

Yes	No	Acetaminophen (Tylenol)	Yes	No	Ibuprofen (Motrin)
Yes	No	Benadryl (for allergic reactions)	Yes	No	Robitussin cough syrup/Cough drops
Yes	No	Antacid (Tums)	Yes	No	Bacitracin/Neosporin Ointment

I hereby give my permission for the nurse or nurse designee to give the above listed over the counter medications at school.

Signature _____

Date: _____