HERMITAGE SCHOOL DISTRICT **Teacher/Homeroom**_____
EDUCATIONAL RECORD EMERGENCY INFORMATION **Grade** _____

1. _____/_____/_____
Student Name: Last, First, Middle Birth date **Home** Phone

_____/_____/_____/_____
Address: House Number Street City State Zip

2. _____/_____/_____/_____
Mother/Guardian Name: Cell Phone Work Place Work Phone

_____/_____/_____/_____
Father/Guardian Name: Cell Phone Work Place Work Phone

Student lives with _____ New address _____yes _____no

3. List o**ther persons, in order, who will assume responsibility for care of child if you can't be reached**:

_____
Relationship Name Address Phone

_____
Relationship Name Address Phone

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4. Please list other children in family: (if additional siblings use other side)

_____
Name Birth date Age Grade

_____
Name Birth date Age Grade

_____
Name Birth date Age Grade

5. _____/_____
Student's Doctor Phone

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6. STUDENT HEALTH HISTORY: Please check if your child has had any of the following:

___ Bee Sting Allergies ____ EPI-PEN ___ Kidney Disease
___ Asthma ____ INHALER ___ Physical Handicaps
___ Chicken Pox Disease (Date)_____ ___ Diabetes
___ Scoliosis ___ Environmental Allergies
___ Convulsions/Seizures (Explain)_____
___ Heart Problems (Explain)_____
___ Food Allergies ___EPI-PEN order (List foods)_____
___ Allergies Meds (Other) _____
___ Other_____

Please list any medications your child is taking: _____

7. ( ) I DO ( ) I DO NOT Give the school permission **to transport my child by ambulance** if deemed necessary
Check preference ( ) Sharon Regional Health System ( ) Horizon UPMC, Farrell

8. CIRCLE Medications your child can receive in school when circled
Grades K-12 Adrenalin (severe allergic reactions), Benadryl, Anti-nausea or Antacid, Cough Medicine (Robitussin)
Additional Meds for Grades 7-12 ONLY
Advil (IBP), Sudafed (decongestant), Tylenol (non-aspirin)

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9. I hereby give permission for emergency treatment, first aid (in school or on bus) and **state mandated screenings** including vision, hearing, height, weight and scoliosis.

Parent/Guardian Signature _____ Date _____

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10. The Commonwealth of Pennsylvania requires that students in grades K, 6, 11 receive **physical examinations and** students in grades K, 3, and 7 receive **dental exams**. Please indicate your choice below:

_____ I give permission for the school physical/dental exam to be performed by the school doctor and/or dentist free of charge.
_____ I will have my child examined by our family physician and/or dentist at my own expense.

Parent/Guardian Signature _____ Date _____