Brimley Area Schools Student Emergency Procedure Sheet
2020-2021

Students Name_____Last_____Middle_____First

Gender Male____ Female___ Birth date_____ Grade/Teacher_____

Home Address_____**Home/Phone**____
Street City Zip

(Please circle person to contact first) parents not living in same household: please include address for other parent.

Father_____work phone_____
Name place of employment
cell phone_____
Email address_____

Mother_____work phone_____
Name place of employment
cell phone_____
Email address_____

Name/Address of parent not living in home:_____

If you cannot be reached, please list the name of a relative or neighbor who can assume temporary care of your child.

Name_____relationship_____Phone_____

Name_____relationship_____Phone_____

To provide relief from occasional minor discomfort, my child has permission to receive the following in compliance with school policy: Please Check Below

_____Acetaminophen _____Ibuprofen _____Benadryl Liquid

_____Tums _____Cough Drops
____Topical Ointments (peroxide, antibiotic ointment, Vaseline, hydrocortisone cream)
____Medicated Ointment for mouth pain (i.e. Anbesol, Orajel)

_____PERMISSION TO TAKE YOUR CHILD'S TEMPERATURE DAILY

(PLEASE COMPLETE FORM ON BACK AND SIGN)

HEALTH INFORMATION-CHECK ALL THAT APPLY

____*__*__**Allergies** (list medicines and other)
_____

_____*__**Asthma**
_____Inhaler at school
_____Carries own inhaler

_____*__**Bee Sting Allergy**
_____Epi- Pen at School
_____Carries own Epi-Pen

_____**Chicken Pox** (had disease)
_____Year had disease

_____*__**Migraine Headaches**

_____**Physical Disability (**please list)
_____

_____*__**Diabetes**
_____insulin dependent

_____**__*Convulsive Seizures**
_____currently on medication
_____date of last seizure

_____**__Heart Condition**
_____type
restrictions Y___N____

_____H**earing Impaired**
_____**Vision Impaired**
_____ wears glasses ____wears contacts

_____**Other** (please list)
_____

***SEE SCHOOL OFFICE PERSONNEL TO COMPLETE CARE PLAN & MEDICATION PAPERS.**

List Current Medications Here: _____
Health Insurance Carrier:_____
Family Doctor's Name/Address: _____

SCHOOL-PARENT UNDERSTANDING:
The procedure we will follow in case of SEVERE injury or LIFE OR DEATH situations:

1. Parent/legal guardian will be notified immediately.
2. Principal, teacher or secretary will summon aid through emergency services for an ambulance and child will be taken to nearest hospital.

Signature of Parent/Legal Guardian_____DATE_____

*Your signature authorizes the school district to place this health information on a confidential medical list. This list is distributed to all staff concerned with your child, and informs them of your child's health needs.

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnosis, and treatment including surgical intervention, if necessary, on behalf of my minor child listed below and to do all other necessary things as I might or could do to provide for the child's health and safety, if I were present.

This authorization is valid for the current school year or until such time as I withdraw the authorization.

Authorized Signature (Parent/Legal Guardian) _____date_____
(Note: Please notify school officials immediately of any changes in information)