

**Corry Area School District**

540 East Pleasant Street  
 Corry PA 16407  
 Phone: (814) 664-4677  
 Fax: (814) 664-9645  
<http://www.corrysd.net>

**Emergency Information Form**

ALL Students  
 Completed by Parent or Guardian  
 Page 1 of 2  
**2024-25 School Year**

**\*PLEASE COMPLETE ALL SECTIONS ON BOTH SIDES****STUDENT INFORMATION Section A**

Legal Last Name:		Legal First Name:		Middle Name:	
Primary Address:				Apt. No:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
City:	State:	Zip:	Birth Date (mm/dd/yyyy):		
Building: <input type="checkbox"/> CAPS <input type="checkbox"/> CAIS <input type="checkbox"/> MS <input type="checkbox"/> HS		HR #:	Entering Grade:		
Teacher:					
Student Lives With (check all that apply):					
<input type="checkbox"/> Both Parents full time		<input type="checkbox"/> Mother		<input type="checkbox"/> Father	
<input type="checkbox"/> Guardian:		<input type="checkbox"/> Other:			
<b>Print Father's Name:</b>			<b>Print Step-Mother's Name:</b>		
Father's Address:			Step-Mother's Address:		
<input type="checkbox"/> Own <input type="checkbox"/> Rent Landlord's Name:			<input type="checkbox"/> Own <input type="checkbox"/> Rent Landlord's Name:		
Employer:	Work #:	Employer:	Work #:		
Home #:	Cell #:	Home #:	Cell #:		
<b>Print Mother's Name:</b>			<b>Print Step-Father's Name:</b>		
Mother's Address:			Step-Father's Address:		
<input type="checkbox"/> Own <input type="checkbox"/> Rent Landlord's Name:			<input type="checkbox"/> Own <input type="checkbox"/> Rent Landlord's Name:		
Employer:	Work #:	Employer:	Work #:		
Home #:	Cell #:	Home #:	Cell #:		
<b>Legal Guardian's Name: (If not living with a parent):</b>					
Guardian's Address:			Relationship:		
<input type="checkbox"/> Own <input type="checkbox"/> Rent Landlord's Name:			Employer:		
Cell #:			Work #:		
Home #:					

**EMERGENCY CONTACT INFORMATION Section B**

**You MUST provide two (2) alternate contacts that ARE NOT already listed in the Parent or Guardian section**

Last Name:	First Name:	Relationship:
Primary Phone:		Cell #:
Last Name:	First Name:	Relationship:
Primary Phone:		Cell #:
Family Doctor:		Phone:
Family Dentist:		Phone:

**SCHOOL REACH Section C**

*Please provide a phone number where the primary parent/guardian can be reached should there be the need to issue a School Reach call. Please note that this number should be your landline number or the cell number of the primary parent or guardian.*

Phone #	Phone #
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**MEDICAL RELEASE Section D**

*Medical information will be shared with school staff as deemed necessary for the safety of your child.*

Does your child have medical insurance?  No  Yes  Private  CHIPS  Medical Assistance

*It is understood that in case of emergency, the school authorities use their own judgement in sending the child to the Corry Memorial Hospital or a physician most easily accessible if the parent/guardian cannot be reached.*

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

STUDENT'S NAME: \_\_\_\_\_

BROTHERS OR SISTERS				Section E
Last Name	First Name	Age	Grade	School

UPDATED MEDICAL HISTORY				Section F			
Condition	Yes	No	Age	Condition	Yes	No	Age
Asthma				Kidney Trouble			
Bed Wetting				Pneumonia			
Chicken Pox				Rheumatic Fever			
Chronic Illness				Scarlet Fever			
Frequent Colds				Concussion			
Type I Diabetes				Whooping Cough			
Type II Diabetes				Seizure Disorder			
Frequent Ear Aches/Infection				Age of Last Seizure:			
Heart Trouble				Other:			
If Yes to any of these conditions, please use this space to explain:				List any immunizations administered during the last year.			

Is your child required to wear glasses?  Yes  No      Is your child required to wear contacts?  Yes  No  
 Is your child required to wear hearing aids?  Yes  No

Does your child have any urinary tract or bowel incontinence problems that might require extra care or preparation in school?  
 Yes  No      If Yes, explain:

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Does your child have any other physical illness or impairment that might affect his/her normal participation or progress in regular school programs: If Yes, explain:

Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Is your child currently under a doctor's care?  Yes  No      If Yes, explain:  
 Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Are there components of this care that would restrict your child's participation in any physical activity at school?  
 Yes  No      If Yes, explain:

*In addition, if you answered Yes to the above, please submit a statement from your doctor detailing the nature and the duration of the restriction.*

Does your child have any health problems which might require emergency treatment while at school?  Yes  No  
 (seizures, bee-sting or food allergies, bleeding, asthma or heart problems)      If Yes, explain:

Treatment plan for bee-sting  Observe  Benadryl  Epi-pen  
 Treatment plan for food allergies  Observe  Benadryl  Epi-pen

*If Epi-pen, you must provide Epi-pen, parent authorization and signed doctor authorization.*

Is your child currently taking prescribed medication?  Yes  No  
 If Yes, please specify:

MEDICATION NAME:	
DOSAGE:	
TIME TAKEN:	

Must medication be administered during school hours?  Yes  No  
*If Yes, you must read Policy 210-Use of Medication and complete the Authorization for Medication to be taken during School Hours Form.*

**MIDDLE-HIGH SCHOOL STUDENTS ONLY**  
 My child may be given pain reliever if needed.

Acetaminophen (Tylenol)  Yes  No      Ibuprofen (Advil)  Yes  No

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_