**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

**2020-21 School Year**

## STUDENT INFORMATION — Section A

| | | | | | |
|---|---|---|---|---|---|
| Legal Last Name: | | Legal First Name: | | Middle Name: | |
| Primary Address: | | | | Apt. No: | Sex: ☐ M ☐ F |
| City: | State: | Zip: | Birth Date (mm/dd/yyyy): | | |
| SS # | Building: | ☐ CAPS ☐ CAIS ☐ MS ☐ HS | | HR #: | Entering Grade: |
| Teacher: | | | | | |
| Student Lives With (check all that apply): | ☐ Both Parents full time ☐ Guardian: | ☐ Mother | ☐ Father ☐ Other: | | |

| | |
|---|---|
| **Print Father's Name:** | **Print Step-Mother's Name:** |
| Father's Address : | Step-Mother's Address: |
| ☐ Own ☐ Rent Landlord's Name: | ☐ Own ☐ Rent Landlord's Name: |
| Employer: / Work #: | Employer: / Work #: |
| Home #: / Cell #: | Home #: / Cell #: |
| **Print Mother's Name:** | **Print Step-Father's Name:** |
| Mother's Address: | Step-Father's Address: |
| ☐ Own ☐ Rent Landlord's Name: | ☐ Own ☐ Rent Landlord's Name: |
| Employer: / Work #: | Employer: / Work #: |
| Home #: / Cell #: | Home #: / Cell #: |

**Legal Guardian's Name: (If not living with a parent):**

| | |
|---|---|
| Guardian's Address: | Relationship: |
| ☐ Own ☐ 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 #

## 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*