

VALLEY WEST SCHOOL

269 MOORE STREET
CHICOPEE, MA 01013

EMERGENCY FORM

Dear Parent/Guardian: Please fill in the following information and return it to school with your child. This information is important in case of illness, or emergency, during school or an emergency dismissal from school.

NO STUDENT WILL BE ALLOWED IN SCHOOL WITHOUT A SIGNED EMERGENCY FORM.

Student's name _____ MI _____ Home phone # _____

Address _____ Birthdate _____ Grade _____

City _____ Zip code _____

Mother _____ Alternate phone# _____

Father _____ Alternate phone# _____

Guardian _____ Alternate phone# _____

Student resides with (please circle): Mother Father Both Other _____

If parent or guardian **cannot be reached** in an emergency, please list names of any responsible adults, who are available during school hours **to pick up your child.**

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Student's physician _____ Phone # _____ Date last visit _____

Student's dentist _____ Phone # _____ Date last visit _____

Student's therapist _____ Phone # _____ Date last visit _____

Student's psychiatrist _____ Phone # _____ Date last visit _____

Student health insurance carrier _____ Policy# _____

Please list all medications that your child takes. **Please notify health office of any medication changes!**

To better serve your child, please circle the following that affect your child:

Heart Condition Diabetes Asthma Seizure Disorder ADD/ADHD Migraines Depression Autism Anxiety

Other (Specify) _____

___ Allergies: *To what? (Food, insects, medication, environment)* Specify _____

___ Epi-pen ___ Inhaler

I agree to have my son/daughter brought to the nearest hospital, E.R. or crisis center for evaluation and treatment, in the event of a medical/psychiatric emergency, which cannot be handled in the school setting.

I give permission to exchange information with any of my child's service providers for the purpose of referral, diagnosis and treatment.

I give consent to Valley West School to request a copy of my child's physical and immunization record from the sending school or physician's office.

I give permission to the school nurse to share this information with the appropriate school personnel.

Signature of Parent/Guardian _____ **Date** _____ **OVER**

OVER THE COUNTER MEDICATION FORM

SUPERFICIAL SKIN/WOUND CLEANSING/TREATMENT:

Benadryl Cream
Calamine Lotion
Hydrogen Peroxide Solution
Isopropyl Alcohol 70%
Petroleum Jelly for dry skin
Antibiotic ointment
Hydrocortisone cream 1%
Silvadene ointment for minor burns
Sun screen
Insect repellent

PAIN/FEVER TREATMENT:

Acetaminophen 325 mg. 1-2 tabs every 4 hours as needed.
Chewable 80mg. for ages 10 and under as directed by bottle instructions. (10-15mg/kg)
Ibuprofen 200mg. 1-2 tabs every 4-6 hours as needed ages 12 & over.
Tablets for children under 12 as directed by bottle instructions regarding age and weight.

EYE IRRIGATION SOLUTION:

Sterile Isotonic Buffered Solution

STOMACH DISCOMFORT:

Antacid/Antigas

Antacid tablets (Tums) 1-2 tablets every 3-4 hrs. as needed over 12 yrs.

Mylanta tablets as directed by age and weight on bottle for Children under 12 years of age.

COUGH/COLD TREATMENT:

Cough Drops Menthol/cetylpyridinum: one cough drop every 1-2 hrs. as needed

Sudafedrine 30mg 1-2 tabs for over age 12 every 4-6 hours and children 6-12 yrs of age 1 tab every 4-6 hours for nasal congestion

PLEASE NOTE

The school nurse may limit students frequent use/abuse of over-the-counter medications

EMERGENCY TREATMENT ONLY

POISONING: Treatment as directed by **Poison Control 1(800)222-1222**

ALLERGIC REACTION:

Diphenhydramine Hydrochloride 25-50mg. (emergency dose) ex: antihistamine- Benadryl

Epi-Pen Jr.: 0.15 mg for children under 60 lbs.

Epi-Pen: 0.3mg for children/adult over 60 lbs.

EMERGENCY TREATMENT for severe allergic reaction/anaphylactic shock

Ex. Bee sting/severe allergic reaction: transport to local hospital for immediate medical attention.

*Every attempt will be made to contact parent/guardian. **Please keep phone numbers and medical information current.**

The proper parent/guardian consent form below **MUST** be on file before **ANY** medication will be given to your child by the school nurse (telephone permission **CANNOT** substitute for a signed, dated consent).

I give my permission for the school nurse to administer the medications prescribed by the school physician.

I have crossed out any product that I do not wish my child to receive.

Signature of parent/guardian _____ Phone number/s _____

Relationship to the student _____ Date _____

Signature of student _____ Date _____

(If 18 yrs. or older)

Dr. John Murphy _____ Date _____

SCHOOL PHYSICIAN'S SIGNATURE