Valley West School

269 Moore Street - Chicopee, MA 01013 - www.valleywestschool.com - 413.592.6069

EMERGENCY FORM

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___ Primary phone # _____

Address_____Birthdate_____Grade_____

City_____ Zip code_____

Parent/Guardian 1_____ Relation_____

Home #_____ Cell #_____ Work #_____

Parent/Guardian 2_____ Relation_____

Home #_____ Cell #_____ Work #_____

Custody: _____ Living Arrangement_____

Email 1:_____ Email 2:_____

If primary contact **cannot be reached** in an emergency, list names of responsible adults available during school hours, **who are able to pick up your child**.

Name_____ Home or Cell #_____ Relationship_____

Name_____ Home or Cell #_____ Relationship_____

Name_____ Home or Cell #_____ Relationship_____

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 Other (Specify) _____

Allergies: Y or N *To what? (Food, insects, medication, environment)* Specify_____

Procedure_____ 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 repellant

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_____

Relationship to the student_____Date_____

Signature of student_____Date_____
(If 18 yrs. or older)

Dr. John Murphy _____Date_____
SCHOOL PHYSICIAN'S SIGNATURE