School_____ Grade/Teacher_____

PRESTON COUNTY SCHOOLS
Emergency & Health Information

Student Name_____ ◯M / F◯ DOB ___/___/___ Bus#_____ /_____
(Last) (First) (MI) (AM) (PM)
Mailing Address_____ City/State_____ Zip_____
Physical Address (Street Address)
_____

Does your child speak a language other than English? ☐Yes ☐No If so, what language? _____
Does either parent speak a language other than English? ☐Yes ☐No If so, what language? _____

	PARENT/GUARDIAN CONTACT	PARENT/GUARDIAN CONTACT
Contact Name		
Relationship to Student		
Mark ALL that Apply	☐Lives With ☐Custodial Parent ☐Permission to Pick up ☐Has Internet	☐Lives With ☐Custodial Parent ☐Permission to Pick up ☐Has Internet
Home Phone #		
Cell phone #		
Place of Work & phone #		
Email address		

List other persons (relative/neighbor) who will assume temporary care of your child if you cannot be reached:
Name_____ Relationship_____ Home#_____ Cell#_____ Work#_____
Name_____ Relationship_____ Home#_____ Cell#_____ Work#_____
☐ Please mark here if you have any new information on this form so that we can update our computer records!

Childcare/Daycare/Afterschool Care Provider's Name & Contact# _____
Siblings in Preston County Schools (name/grade/school)_____

Confidential Information Box 1
Complete this box ONLY IF (1) **it reflects your child's current living situation**; OR (2) **it reflects your living situation if you are a youth NOT living with a Parent or Guardian** (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Circle which applies to your living arrangements:
◯In an abandoned apartment/building ◯In a car/park/other public place ◯In a hotel/motel
◯In a Shelter ◯In a residence of other individuals or family ◯In a Foster Care

Confidential Information Box 2
Is there current Order of Protection or No Contact Order which concerns this student? Yes ☐ No ☐
NOTE: If marked yes, school must be provided a copy of the court order

	NAME	ADDRESS	PHONE	Date of Last Exam
Healthcare Provider				
Dentist				

Student's Health Insurance Coverage (select one):
☐WV Medicaid ☐WV CHIP ☐Private/Employer Health Insurance Medical Card/Policy#_____
☐No Insurance (Please contact WVDHHR or www.wvinroads.org or www.healthcare.gov to apply for coverage)

I/WE, THE UNDERSIGNED DO HEREBY AUTHORIZE OFFICIALS OF PRESTON COUNTY SCHOOLS TO CONTACT DIRECTLY THE PERSONS NAMED ON THIS FORM AND DO AUTHORIZE THE NAMED HEALTHCARE PROVIDERS TO RENDER SUCH TREATMENT AS MAY DEEMED NECESSARY IN AN EMERGENCY, FOR THE HEALTH OF SAID CHILD.
IN THE EVEN THE HEALTHCARE PROVIDERS, OTHER PERSONS NAMED ON THIS FORM OR PARENTS CAN NOT BE CONTACTED, THE SCHOOL OFFICIALS ARE HEREBY AUTHORIZED TO TAKE WHATEVER ACTION IS DEEMED NECESSARY IN THEIR JUDGEMENT FOR THE HEALTH OF THE SAID CHILD.
I/WE WILL NOT HOLD THE PRESTON COUNTY BOARD OF EDUCATION FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND/OR TRANSPORTATION OF SAID CHILD.

Signature of Parent/Guardian_____ Date___/___/___
Please complete information on both sides of this form

School_____ Grade/Teacher_____

PRESTON COUNTY SCHOOLS
Emergency & Health Information

- We ask you to complete this form at the beginning of every school year to ensure we have the most current information.
- The school district intends to use the requested information to provide for your child's health & safety while at school.
- The information provided will only be shared with staff whose position requires access to this information to ensure your child's safety or support their educational progress.
- If an emergency situation should occur we will call 911 for assistance if needed and notify you or your designee.
- Please contact your school promptly with any changes in your information.
- Parents are encouraged to contact Teachers directly, if there is issues that impact your child's learning.
- Please contact your School Nurse directly, regarding your child's healthcare needs at school.
- Parents are expected to alert Bus Drivers of any medical condition that may occur on bus.

ALLERGIES:	**MEDICAL CONDITIONS (diagnosed by a Healthcare Provider):**	MEDICATIONS:
List ALL allergies to stings, food, medications, latex, etc. *If your child requires EpiPen or Benadryl please provide the Healthcare Provider's signed Diagnosis and Medication Order to your School Nurse	such as Asthma, Diabetes, Seizures, ADD/ADHD, Autism, Chronic Conditions, Bipolar, Depression, Schizophrenia, etc.	List all medications your child is currently taking and star (*) the ones to be given at school. NOTE: A signed order from your Healthcare Provider is required for any medication (Prescription or Over The Counter) to be given at school.

My Child has Asthma: ☐ YES ☐ NO
*Please obtain an Asthma Action Plan from your Healthcare Provider and give copy to your School Nurse. Or see your School Nurse for a form to submit to your provider.

My Child has Seizures: ☐ YES ☐ NO
*Please obtain a WV Seizure Action Plan for School from your Healthcare Provider and give copy to your School Nurse

My Child has a Food Allergy diagnosed by a Healthcare Provider: ☐ YES ☐ NO
*Please obtain the required Special Diet Order packet from your School Nurse. These forms are required to be completed by your provider, before any modifications to school meals can be made.

IMMUNIZATIONS: Please list immunizations your child has received within the last year
Shot Type_____ Date received ___/___/___ Shot Type_____ Date received ___/___/___
*Please provide an updated shot record to your School Nurse.
*If your child is entering 7th or 12th grade they are required to show proof of Tdap and Meningitis Immunizations

Other information about your child that you feel it is important for us to know:

Signature of Parent/Guardian_____ Date___/___/___
Please complete information on both sides of this form