CRAWFORD COUNTY CAREER & TECHNICAL CENTER
EMERGENCY PROCEDURE CARD

PLEASE COMPLETE

Contact Phone # _____
Sending School _____
Birth Date _____
Gender _____

STUDENT'S NAME _____
(Last) (First) (Middle)

ADDRESS _____
(Street Address) (City) (Zip Code)

GRADE _____ SHOP _____ SESSION _____
(10/11/12) (AM/PM)

In case of an emergency, illness or accident, the school is authorized to seek medical services as needed. In case of an emergency, parent/guardian can be contacted at the following:

Father / Guardian _____ _____ _____
(First & Last Name) (Home Address – if different than above) (Home/Cell Phone #)

_____ _____ _____
(E-Mail Address) (Name of Employer) (Work Phone #)

Mother / Guardian _____ _____ _____
(First & Last Name) (Home Address – if different than above) (Home/Cell Phone #)

_____ _____ _____
(E-Mail Address) (Name of Employer) (Work Phone #)

Student Resides With (Please check all that apply): _____ Mother _____ Father _____ Guardian

In case parents cannot be reached call: _____ _____ _____
(Name) (Relationship to Student) (Phone #)

In case parents cannot be reached call: _____ _____ _____
(Name) (Relationship to Student) (Phone #)

Accident / Illness – Please be advised that the Crawford County Career & Technical Center (Crawford Tech) employs a Health Technician. The Health Technician will attend to minor injuries and illnesses. Parents will be contacted prior to a child being dismissed due to illness. In the event of an emergency, Crawford Tech staff will contact 911. At the same time, a parent or guardian will be contacted. In the event of a serious medical emergency, if the parent cannot be contacted, the student will be transported to the Meadville Medical Center for evaluation and treatment. Crawford Tech **does not** carry any medical or accident insurance for its students; parents will be responsible for all costs associated with medical treatment. Supplemental accident insurance is available at your son or daughter's sending school. All career & technical students will receive proper training in general safety and the operation of power equipment used in their field of study. However, even with appropriate supervision and training, accidents may occur. Your signature states that you recognize the potential dangers associated with the lab work and/or field work that are essential in your child's technical training.

Computer / Internet User Agreement –Your signature indicates that you have read and agree to abide by Crawford Tech's Computer and Network User Agreement as written in the Student Handbook. Should your child commit any violation, their access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action.

Photo Release – Your permission is requested to have your child photographed for use in promotional materials, such as the school's website, yearbook and posters. Your signature indicates that you have read and agree to Crawford Tech's Photo Release as written in the Student Handbook.

Please list a valid e-mail address as this is the preferred method of contact when your child is absent. If at any time during the school year the above information changes, new emergency cards will need to be completed and returned to Crawford Tech's Main Office.

I certify that I have read and agree to all of the conditions stated in the above policy; have provided correct information; and **I have reviewed the Crawford County Career & Technical Center's Student Handbook** and am familiar with its policy and procedures. In the event the above persons cannot be reached in an emergency, I hereby give permission to any licensed physician to take care of my child.

Student's Signature _____

Parent's/Guardian's Signature _____

PLEASE COMPLETE MEDICAL INFORMATION ON REVERSE SIDE

MEDICAL INFORMATION

*Notify Health Technician / School immediately of any changes

Student's Full Name: _____ Birthdate: _____ Grade: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Does your child have any **health problems** or **physical limitations** that the school nurse or teacher should know?

Yes _____ No _____ Explain: _____

***If you answered yes to the above, please submit documentation from your doctor detailing the nature and the duration of the restriction and/or medical conditions.**

Hospitalization in the last year: Yes _____ No _____

Reason: _____

Concussion in the last year: Yes _____ No _____

List all Medications, vitamins, etc (with dosage and frequency) that your child takes at home or school.
(Parents must provide the school a Medication Form signed by a Doctor and Parent and the medication in its original bottle if student needs at school):

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Does your student use an inhaler? Yes _____ No _____ (Parent must provide the school a medication form signed by a Doctor and Parent)

Name of inhaler, frequency, dose, diagnosis if known: _____

Does your child have **severe allergies** (latex, bee, etc) Yes _____ No _____

Is your child prescribed an **Epi-Pen**? Yes _____ No _____

List all Food and Medication Allergies / Reactions: _____

Does your child have vision or hearing problems: Yes _____ No _____

Please Explain: _____

Date of Last Tetanus Shot: _____

I hereby give consent for treatment for minor ailments, emergency care, as deemed necessary by the school's Health Technician, the covering CSN of Crawford Central, the physician, or the state. I also give consent and authorize the school's Health Technician to communicate with my child's sending school, my child's treating physicians/dentist, and authorize release of the immunization and medical records between the sending school and the Crawford County Career & Technical Center, as well as between the child's treating physicians and dentist. Medical information will be shared with school staff as deemed necessary for the safety of your child.

Parent/Guardian Signature: _____ Date: _____

CRAWFORD COUNTY CAREER & TECHNICAL CENTER MEDICATION ADMINISTRATION PERMISSION

School Physician orders allow for administration of any school oral medication up to 4 times a month.
Please initial by each medication you permit your student to receive during school hours.

** Ibuprofen (Motrin/Advil)		** Acetaminophen (Tylenol)		** Benadryl for Allergic Reactions	
Visine		Bacitracin Ointment		Antacids (Tums)	
Sting Relief Swab		1% Hydrocortisone		Anbesol/Oragel	
Bio-Freeze (muscle rub)		Sore Throat Spray		Aloe	
Burn Gel		Callergy Clear		Cough Drops	
		Antifungal Cream			

I consent to the use of the above initialed over the counter medications for my child. They will only be administered as needed. Dosing may not exceed the manufacturer's recommended dose or school physician's order.

Parent/Guardian Signature: _____ Date: _____