JUNIATA MENNONITE SCHOOL

289 Leonard Hill Road, McAlisterville PA 17049
Tel. 717-463-2898 Fax 717-463-0134
jmsoffice@tiu11.org

Emergency Information
Student Name:____ Grade: _______________ Gender: _____________
Street Address: ____
City: ____ State: ________ Zip Code: ___________________
Father's Name: ____ Home Phone: ________________________
Father's Employer: ____ Work Phone: _________________________
Cell Phone: __________________________
Mother's Name: ____ Home Phone: ________________________
Mother's Employer: ____ Work Phone: _________________________
Cell Phone: __________________________
Guardian's Name: ____ Home Phone: ________________________
Guardian's Employer: ____ Work Phone: _________________________
Cell Phone: __________________________
Student lives with: □ Both Parents □ Father □ Mother □ Guardian □ Foster Family
□ Father and Stepmother □ Mother and Stepfather □ Other: ____________________

Custody information on file with the school? □ Yes □ No
(please check one if separated or divorced)

Emergency Contacts (other than parents)
Name: ____ Relationship**:** _________________________________
Phone: ____ Alternative Phone:______________________________
Name: ____ Relationship**:** _________________________________
Phone: ____ Alternative Phone:______________________________
Name: ____ Relationship**:** _________________________________
Phone: ____ Alternative Phone:______________________________
Physician's Name: _____________________________________ Physician's phone: _____________________________
Dentist's Name: _______________________________________ Dentist's phone: _______________________________

In the event of any emergency, the school will attempt to contact the parents, guardians and emergency contact persons. If the school is unable to reach them, the undersigned authorizes the school to contact the physician listed above and follow his/her instructions. If the physician cannot be reached, the undersigned authorizes the school to make whatever arrangements it deems necessary for the health and safety of the child.
Parent/Guardian signature: ____ Date: ____________________________

Special Health Concerns
Student Name: ____ Grade: ___________ Gender: __________
Asthma? □ Yes □ No Emergency inhaler needed at school? □ Yes □ No
Seizures? □ Yes □ No If yes, type?____
Date of last seizure: ____

Diabetes? □ Yes □ No If yes, □ Type 1 □ Type 2
Diet restrictions: ____
Cardiac
Condition? □ Yes □ No If yes, gym restrictions? □ Yes □ No

Severe
Allergies? □ Yes □ No □ peanuts □ tree nuts □ milk □ shellfish
□other allergies: ____
Drug
Allergies? □ Yes □ No If yes, please list: ____

Other medical
Conditions? □ Yes □No If yes, please list: ____

Emotional
Problems? □ Yes □ No If yes, please list ____

Serious illness, injury hospitalization or operation? □ Yes □ No
If yes, date: ________________ Describe: ____
Still under treatment? □ Yes □ No

Restrictions on physical activity? □ Yes □ No
Describe: ____

Medications (taken at home or in school)
Name: ____________________ Dose: ___________ Times: ________________ Reason: _________________________________

Name: ____________________ Dose: ___________ Times: ________________ Reason: _________________________________

Name: ____________________ Dose: ___________ Times: ________________ Reason: _________________________________

Name: ____________________ Dose: ___________ Times: ________________ Reason: _________________________________

Name: ____________________ Dose: ___________ Times: ________________ Reason: _________________________________

□ glasses □ contact lenses □ hearing aids □ ear tubes
□ other devices: ____

The school office staff may prepare a confidential list of students with significant health concerns of which teachers and staff should be aware to protect the health and well-being of those students. By signing below, you allow the office staff to share any health information she/he deems appropriate for persons caring for your child to know.

Parent/Guardian signature: ____ Date: _____________________