MCIU MONTGOMERY COUNTY INTERMEDIATE UNIT 23
2 West Lafayette Street | Norristown PA 19401 | 610-755-9400 | www.mciu.org

2023-2024
EMERGENCY FORM

STUDENT NAME:_____ **DOB:**_____
(Last) (First)

ADDRESS:_____

_____

PARENT/ GUARDIAN: ***Name***:_____

Address:_____

_____

Parent email address:_____

Home #:_____ **Work #**:_____ **Cell #:** _____

PARENT/ GUARDIAN: ***Name:***_____

Address: _____

_____

Parent email address:_____

Home #:_____ **Work #**:_____ **Cell #:** _____

IF THE PARENT OR GUARDIAN IS UNAVAILABLE, SHOULD AN EMERGENCY SITUATION OCCUR, THE FOLLOWING PEOPLE SHOULD BE CONTACTED.

NAME:_____ **RELATIONSHIP:**_____

Home #:_____ **Work #**:_____ **Cell #:** _____

NAME:_____ **RELATIONSHIP:**_____

Home #:_____ **Work #**:_____ **Cell #:** _____

2023-2024 **Student:**_____
EMERGENCY FORM
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Any known drug allergies:_____

List any medication student is currently taking:

MEDICATION NAME	DOSAGE	TIME GIVEN

Special notes regarding your child:_____

_____

Protocol regarding missed doses: (student refuses) _____

I give permission for my child to receive prescription medication in school. These medications must be in their original pharmacy container, with specific instructions from the physician listed on the bottle for the R.N.

YES_____ NO_____ (Please Initial)

I give permission to The Anderson School Principal/Nurse/Clinical staff to communicate and/or exchange information, if necessary, with my child's physician.

YES_____ NO_____ (Please Initial)

Name of Physician:_____ Phone #:_____

I give permission to the Principal or Clinical staff to communicate and exchange information with my child's counselor, therapist, psychologist, psychiatrist or wraparound:

YES_____ NO_____ (Please Initial)

Name:_____ Agency:_____ Phone #:_____

_____ _____
Parent/Guardian Signature Date

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2023-2024 Health Information

Student Name: **Grade:** **DOB:**

In the event the parent/guardian cannot be reached, list two local contacts who will assume temporary care of your child:

Name	Relationship	Phone #	Able to Transport Student
1.			☐ **Yes** ☐ **No**
2.			☐ **Yes** ☐ **No**

My child receives medical care for a health condition (Check all that apply):

☐ **Arthritis/Rheumatic Disease**	☐ **Cerebral Palsy**	☐ **Sickle Cell Disease**
☐ **Asthma: Inhaler needed ☐ Y ☐ N ***	☐ **Cystic Fibrosis**	☐ **Spina Bifida**
☐ **ADD/ADHD**	☐ **Diabetes Type I ☐ Type II ☐**	☐ **Tourette's Syndrome**
☐ **Bleeding Disorder**	☐ **Life Threating Allergies *** **	☐ **Glasses/Contact Lenses**
☐ **Heart Condition**	☐ **Seizure Disorder**	☐ **Other Health Concerns ****

List prescription or over the counter medications (OTC)/supplements your student takes regularly at home:

*** If Asthma is checked: The parent/guardian is required to provide the school nurse EVERY YEAR with an Inhaler and updated *Asthma Action Plan* including a doctor's signature.**

**** If Other Health Concern if checked, please provide explanation:**

***** Please list any <u>medically documented</u> allergies and the noticeable reactions:**

Does your student require an Epi-pen for their allergy? ☐ Yes ☐ No

Please note: The parent/guardian is required to provide the school nurse EVERY YEAR with an Epi-pen and updated *Allergy/Anaphylaxis Action Plan* including a doctor's signature.

I give the school nurse permission to administer the following over the counter medication as needed: **Acetaminophen (Tylenol), Ibuprofen (Advil), Cough drops, Benadryl, Chloraseptic Spray, Tums, First Aid Cream, Caladryl.** Generic medications may be substituted. Ibuprofen is limited to 2 doses/week without a written doctor's note.

Parent signature (required): ☐ **Yes** ☐ **No**

<u>PLEASE NOTE</u>: All other medications (including over the counter medications) administered at school requires complete and updated physician orders including doctor's signature along with parent permission/signature.

PA State School Requirements

***** Prior to or on the first day of school*****

***Kindergarten, 1st grade or new PA students*:** an updated immunization record. Students **must** have received the first immunization for each series of **DtaP, IPV, Hepatitis B, MMR, Varicella**

***7th grade*:** an updated immunization record. Students should have completed all **DtaP, IPV, Hepatitis B, MMR, Varicella** series. Additionally, one dose of **Tdap (tetanus, diphtheria, acellular pertussis** and one dose of **MCV (meningococcal conjugate vaccine)**

***12th grade*:** an updated immunization record. Students should have completed all **DtaP, IPV, Hepatitis B, MMR, Varicella** series. Additionally, second dose of **MCV (meningococcal conjugate vaccine)**

***** Prior to November 1st, 2023, the following examinations are due to the school nurse*****

***Kindergarten, 1st grade or new PA students*:** a physical AND dental exam (must be dated on or after July 1, 2022)

***3rd grade*:** an updated dental exam

***6th grade*:** an updated physical with immunization record

***7th grade*:** an updated dental exam

***11th grade*:** an updated physical with immunization record

All forms are available on the Anderson website under the forms tab

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In case of an emergency, when parents or emergency contacts cannot be reached, I give permission to school authorities to use their judgment in obtaining care for my student. Any cost incurred will be the responsibility of the parent/guardian. *** I acknowledge this: _____ (**parent/guardian initials)

I have reviewed the information on this form and will update the school nurse's office with any changes or immunization updates.

Parent/Guardian signature (required): Date:

Parent/Guardian Name (please print):

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The Anderson School
930 Jefferson Avenue, Eagleville, PA 19403
610-635-2400

SUBJECT: Over-the-Counter Medications

Dear Parents/Guardians:

According to The Anderson School's Medical Standing Orders, the following medications may be administered to students by the School Nurse or School Nurse Substitute. However, your consent is needed to do so.

Also, if any of these medications is required for indefinite or daily use, our Medical Standing Orders require a written consent from the primary care physician.

Please fill in the student's name, initial each medication that may be given at school, and return to the school. **This form must be on file, or these medications cannot be administered to your student.**

Name_____

_____Acetaminophen (i.e. Tylenol)
_____Anbesol or Orajel (or generic)
_____Antacid (i.e Tums—NOT Pepto-Bismol, which contains salicylates)
_____Antibiotic cream or ointment (i.e. Neosporin or generic)
_____Antifungal cream (i.e. Lotrimin or generic)
_____Antihistamine cream/lotion (i.e. Caladryl—Calamine lotion containing Benadryl)
_____Antihistamine (oral medication, i.e. Benadryl)
_____Anti-itch cream/lotion (i.e. Calamine Lotion)
_____Cough drops/throat lozenges/throat gargle
_____First Aid cream
_____Epi Pen (for severe allergic reaction)

Does Student have an allergy or sensitivity to

Aspirin YES_____ NO_____
Benadryl YES_____ NO_____

NOTE: Aspirin or products containing aspirin (salicylates) will not be administered in the school setting.

Parent/Guardian Signature Date

Agency Intervention:

Has student received services from an outside agency in the past? Y or N
Agency:_____ What were the results?_____

_____

_____

Is student currently receiving services from an agency? Y or N
Agency:_____

Reason:

_____

_____

Contact Person:_____ Contact's Phone #:_____

Psychologist/Psychiatrist:_____ Phone #:_____

Involvement with Children & Youth: Y or N Reason:_____

_____

Case Worker:_____ Contact #:_____

Involvement with Law Enforcement: Y or N

Reason:_____

_____

Name of Probation Officer:_____

Probation Officer #:_____

Date Placed on Probation:_____

Medical History:

Known Medical Conditions:_____

Any Additional Medical Information:_____

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Dear Parent or Guardian:

We are pleased to inform you that volunteers from the **Alliance of Therapy Dogs** program will be interacting with our students at Anderson and Explorations.

The **THERAPY DOG** program is dedicated to improving the speaking and reading skills of students using certified Pet Therapy teams. Being with a therapy dog can also alleviate symptoms of depression, anxiety and trauma.

This permission form is to let you know that there will be therapy dogs in our school on certain days throughout the school year. Handlers and their dogs work with students recommended by their teacher for approximately 15 minutes. The dogs and their handlers have been insured for liability and have registration to do animal-assisted therapy.

Participation in this program will not begin until your written permission is received. **Please return this form to the school if you are interested.** Should you have any questions or concerns, please feel free to contact your child's teacher.

Sincerely,

Christine Raber
Principal
craber@mciu.org

PLEASE COMPLETE AND RETURN

CHECK ONE:

_____ I **DO** give permission for my child to participate in the **THERAPY DOG** program.

_____ I **DO NOT** give permission for my child to participate in the **THERAPY DOG** program.

Student's Name_____

Parent/Guardian Signature _____

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STUDENT MEDIA CONSENT AND RELEASE FORM

Throughout the school year, students may be highlighted in efforts to promote MCIU activities and achievements. For example, students may be featured in materials to train teachers and/or increase public awareness of the MCIU and our programs through newspapers, radio, television, the internet, DVDs, displays, brochures, and other types of media.

The undersigned hereby authorizes and grants to MCIU, its employees, representatives and authorized media organizations and assigns an irrevocable license and permission to use my child's name, photograph, likeness, voice, testimonial and biographical material, in whole or in part, for publication or reproduction in any medium including but not limited to television, radio, print media and the Internet, among others, for any purpose including but not limited to public relations, education, advertising, marketing, training and research. My consent extends to such use without restriction or limitation as to time or geographic boundary.

I hereby waive all rights I may have to any claims or demands for payment or royalties in connection with the use of any such materials, regardless of the purpose of such use or publication, and regardless of whether a fee is charged or collected by MCIU for any product and/or service in connection with such use and publication. I also waive any right to inspect, review or approve any photograph, recording or other written material at any time, and waive the right to approve the use and medium of publication determined by MCIU.

I understand that MCIU owns all rights in and to any such photograph, recording or testimonial, including any copyright and/or trademark relating to such use, which MCIU may be entitled to claim.

I further release and relieve MCIU, its Board of Directors, employees, and other representatives from any liabilities, known or unknown arising out of the use of this material.

I declare that I am the legal guardian of the student named below, am at least eighteen (18) years of age, and am legally competent to execute this assignment and release.

I certify that I have read and fully understand the terms and conditions of this Student Media Consent and Release Form and have the right and authority to execute this document.

The undersigned is the Parent and/or Legal Guardian of the named Minor and executes this permission and consent and release agreement and joins therein, on behalf of such Minor.

Student Name:_____ Date: _____

Signature of Legal Guardian:_____ Email address: _____

Print Name: _____

Address:_____ Telephone:_____

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2023-2024
The Anderson School
Computer & Internet Usage

I understand that computer and internet usage is to facilitate my educational growth in technology and information systems.

I understand I may not access any site which is defamatory, inaccurate, profane, sexually- oriented, violent (including weapons), threatening, racially offensive or which contains illegal material.

I will not transfer copyrighted materials to or from an Anderson computer. I understand that this is a violation of federal law.

I will not access or use email or send instant messages from Anderson computers.

I will not attempt to circumvent system security, guess passwords, or in any way, gain unauthorized access to local or network resources.

I understand if I violate these guidelines, I will be denied future use of the computer for a defined period of time and/or receive other disciplinary measures, including possible legal intervention by the Montgomery County Intermediate Unit.

Student signature:_____ Date:_____

Parent signature:_____ Date _____

Staff signature:_____ Date _____

Administrator signature: _____ Date _____