

Student Safety Pledge

Please read and complete the student safety pledge:

Student name _____, who is enrolled in Upper Bucks County Technical School, will, as a part of the technical experience, operate machinery, power equipment, and various tools of the occupation in a safe manner with written permission from a parent/guardian.

It is understood that each student will be given proper instruction, both in the use of equipment and correct safety procedures concerning it, before being allowed to operate equipment. The student must assume responsibility for following safe practices. The student promises to subscribe to the following pledge:

1. I promise to follow **all** safety rules for the technical program.
2. I promise **never** to use a piece of equipment without first having permission from the teacher.
3. I will **not** ask permission to use a particular piece of equipment unless I have been instructed in its use and have been cleared for the proper operation of that particular piece of equipment.
4. I promise **never** to use equipment that does not have all safety features in place.
5. I will report **any** accident or injury to the teacher **immediately**.
6. I will **only** operate a piece of equipment for its intended use.

Student signature _____ Date _____

Parent/Guardian signature _____ Date _____

Authorization for News Media

I/We, the parent/guardian of hereby authorize Upper Bucks County Technical School, local newspapers, television news media, or its representatives, to photograph and/or video my son/daughter while participating in various school activities. It is understood that photographs or testimonials can be used for the purpose of program promotion, career information, school web pages, and/or displays. We further agree to hold harmless, Upper Bucks County Technical School or its successors, from any claim resulting from all purposes, without limitation.

Student signature _____ Date _____

Parent/Guardian signature _____ Date _____

Upper Bucks County Technical School

2022-2023 Confidential Student Health & Emergency Record

***Students will not be permitted to participate
in lab activities until this form is complete***

Student Name _____ Birth Date _____ Age _____
Home High School _____ Program _____ AM PM Grade _____
Primary Address _____ Town _____ Zip _____
Primary Email Address _____
Mother/Guardian _____ Home # _____ Cell # _____
Place of Employment _____ Work # _____
Father/Guardian _____ Home # _____ Cell # _____
Place of Employment _____ Work # _____
Student resides with: Both Parents ___ Mother ___ Father ___ Guardian (name) _____

Emergency Contacts:

(List two adults over 18 years old who are able to pick up your student during school hours)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Student's Doctor _____ Phone _____

Student's Dentist _____ Phone _____

Medical Insurance _____ Policy Number _____

Date of Last Tetanus Booster _____

******PLEASE FILL OUT NEXT PAGE OF FORM******

Student Name _____

PLEASE CHECK IF THE STUDENT HAS ANY OF THE MEDICAL PROBLEMS LISTED BELOW

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> *FOOD ALLERGY	<input type="checkbox"/> *BEE/INSECT ALLERGY	<input type="checkbox"/> *OTHER ALLERGIES
<input type="checkbox"/> INHALER NEEDED IN SCHOOL	<input type="checkbox"/> HEART CONDITION	<input type="checkbox"/> MEDICATION ALLERGY	<input type="checkbox"/> BLEEDING DISORDER
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HEARING PROBLEM	<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> EMOTIONAL
<input type="checkbox"/> GI DISORDER	<input type="checkbox"/> VISION PROBLEM	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> OTHER

*If a student requires an Epi-Pen one must be kept in the health office or on the student (with Doctor's permission) as well as a Medication Administration form.

Please explain any of the above checked conditions, or any other special health problems you would like the Nurse to be aware of _____

Please list medications the student takes on a daily or as needed basis (school or home) _____

**If the student requires medication (prescription & non -prescription) to be given at school a Medication Administration form needs to be signed & the medication should be sent in the original prescription bottle.

The school physician has written standing orders for the following medications to be given by the school nurse if necessary and with parental consent. Permission for medication is not valid without parent/guardian signature (see below) Please CHECK EACH MEDICATION which may be given to your child (Generic equivalent products may be provided)			
<input type="checkbox"/> Advil	<input type="checkbox"/> Antacid Tablet	<input type="checkbox"/> Benadryl	<input type="checkbox"/> Tylenol

It is the utmost importance that all known medical information relating to your child is listed on this form and is updated as needed. If the parent/guardian can't be immediately contacted during an emergency, I understand Upper Bucks Technical School will secure medical attention for my child as deemed necessary. I release any staff member from liability for action taken on my behalf during a medical emergency regarding my child. I understand that the information is confidential. I give permission for my child to be treated at the Health Office and that my child's information may be shared with others who have a need to know to insure a safe environment for my child.

Parent/Guardian Signature _____ Date _____