**Friendship Academy**

**Emergency Care Form**

**2021-2022 School Year**

**Please Print. Answer ALL questions and return to Friendship Academy.**

|  |  |  |
| --- | --- | --- |
| Student Name: | | |
| Address: | | |
| Gender (circle):  M F | Date of Birth: | Phone #: |
| **Student resides with (check all that apply) Add phone number where individual can be reached during the day:** | | |
|  Mother’s Name:  Phone number: E-mail Address: | | |
|  Father’s Name:  Phone number: E-mail Address: | | |
|  Guardian’s Name:  Phone number: E-mail Address: | | |

**Emergency Contacts**

**In case of illness or injury, when neither parent/guardian can be reached, PRINT names of individuals who should be contacted. By providing this information, you are giving permission for the persons listed below to be contacted in case of an emergency.**

|  |
| --- |
| Name: Phone number: |
| Name: Phone number: |

**Health Information**

**If additional room is needed, please use the space provided at the bottom of this form.**

Check any health conditions that your child may have:  Asthma  Diabetes  Epilepsy  Allergies (drug/food)

 Other Conditions:

List allergies to drugs/food:

List ALL medications your child is taking:

**(Turn over to complete Page 2)**

Does your child have health care insurance (CHIP, Medicaid or Private) coverage?  Yes  No

**Insurance Carrier**: Gateway UPMC for You United Healthcare

UPMC Highmark Other:

**Insurance ID**:

**Required Vaccines**

**It is required that all children who did not have chickenpox disease get a second vaccine.**

Date of 2nd chickenpox (varivax) vaccine: or my child had chickenpox at age/date

**It is also required that all children in grades 7-12 get a Tdap vaccine and 1 dose of Menactra (meningitis) vaccine to enter 7th Grade and 1 dose to enter 12th Grade.**

Date of Tdap vaccine: Dates of Meningitis vaccine: 1 2 \_\_\_\_\_\_

**State Required Physical**

**The commonwealth of PA mandates that all students have a physical examination in grades K-1, 6 & 9. The examination may be done by your family physician or health care provider. If your child is in Grades K-1, 6 or 9, please answer statement below.**

1. I will have my child’s physical examination to be completed by our family physician or health care provider and sent to the school nurse. Yes  No

**NOTE: Please send record of physical examination to the School Nurse by September 29th or within 1 month of enrollment.**

**Consent to Obtain Health Records**

**I give consent for the school to obtain immunization information and/or a copy of the last physical from my child’s physician. Yes  No**

Physician’s Name: Phone #:

**Consent for Treatment of Child**

In addition to First Aid, the School Nurse may treat my child with the following. Check Yes or No for each:

|  |  |  |  |
| --- | --- | --- | --- |
| **Tylenol** Yes  No  (Acetaminophen) | **Antacid** Yes  No  (Stomach ache) | **Benadryl** Yes  No  (Allergy medicine) | **Ibuprofen** Yes  No  (Advil/Motrin) |
| **Hydrogen peroxide**  Yes  No (for cleaning cuts and scrapes) | **Hydrocortisone ointment** Yes  No  (anti-itch ointment) | **A&D ointment**  Yes  No  (Skin protectant) | **Oral gel** Yes  No  (for oral and tooth pain) |
| **Cherry Chloraseptic Throat Spray** Yes   No (Phenol 1.4% for throat pain) | **Sunscreen** Yes  No  (topical skin protectant against UV rays) |  |  |

By my signature, I give my consent to the school to carry out ALL items indicated by “Yes” responses above.

Parent/Guardian Signature (Full Name) Date

Additional Information (Medical conditions, allergies, etc.)