Friendship Academy
Emergency Care Form
2024-2025 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. PLEASE ENSURE THAT INDIVIDUALS LISTED BELOW HAVE TRANSPORTATION AVAILABLE TO PICK UP YOUR CHILD IF NEEDED.

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: _____

Consent for Treatment of Child

I give consent for the school to provide vision, hearing, dental, and health screenings as available at school. ❒Yes ❒ No

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 #: _____

In addition to First Aid, the School Nurse may treat my child with the following over the counter products

(No over the counter medications will be administered without this signed form):

❒Yes **TO ALL**

❒ No **TO ALL**

Or 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)	**Skin lotion/ Chapstick** ❒Yes ❒ No (Skin protectant)
Antibacterial Ointment ❒Yes ❒ No (for cuts and scrapes)	**Hydrocortisone cream** ❒Yes ❒ No (anti-itch ointment)	**Artificial Tears** ❒Yes ❒ No (dry eyes/ eye irritation)	**A&D ointment** ❒Yes ❒ No (Skin protectant)	**Oral Pain Relief gel** ❒Yes ❒ No (for oral and tooth pain)

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.)

_____

_____