

**Friendship Academy
Emergency Care Form
2026-2027 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:		
☐ Name and relationship: Phone number: _____ E-mail Address: _____		
☐ Name and relationship: Phone number: _____ E-mail Address: _____		
☐ Name and relationship: 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 on back

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 used without this signed form):

Acetaminophen (Tylenol)	Antacid (Stomach ache)	Benadryl (Allergy medicine)	Ibuprofen (Advil/Motrin)	Skin lotion/ Chapstick (Skin protectant)
Antibacterial Ointment (for cuts and scrapes)	Hydrocortisone cream (anti-itch ointment)	Artificial Tears (Visine for dry eyes/ eye irritation)	A&D ointment (Skin protectant)	Oral Pain Relief gel (for oral and tooth pain)

☐ Yes **TO ALL**

☐ No **TO ALL**

☐ **ALL Except:** _____

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

Parent/Guardian Signature

Date

Additional Information (Medical conditions, allergies, etc.)
