



THE SCHOOL DISTRICT OF PHILADELPHIA

Student Emergency /Medical Information

Last Name: _____ First Name: _____ DOB: _____
 School: _____ Room/Sec: _____ Grade: _____

Home Address: _____ Home phone: _____
 Mother: _____ email: _____ phone: _____
 Father: _____ email: _____ phone: _____
 Guardian: _____ email: _____ phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child	Phone
1. _____	_____
2. _____	_____

Childs Doctor/Clinic: _____ Phone: _____
Medical Insurance: MA ___ CHIP ___ Private ___
 Insurance company name: _____ Policy Number _____

<p>Please circle below to give permission to the school nurse to give your child medication.</p> <table border="1"> <tr> <td>Acetaminophen (Tylenol)</td> <td>YES</td> <td>NO</td> </tr> <tr> <td>Ibuprofen (Advil, Motrin)</td> <td>YES</td> <td>NO</td> </tr> </table>	Acetaminophen (Tylenol)	YES	NO	Ibuprofen (Advil, Motrin)	YES	NO	<p>Please CIRCLE the following if your child:</p> <p>Wears: Glasses Hearing aid Has: Seizures Diabetes Asthma ADHD</p> <p>List Allergies: Food substitution requires a new order yearly from a health care provider: _____</p> <p>Other Health Problems: _____</p>
Acetaminophen (Tylenol)	YES	NO					
Ibuprofen (Advil, Motrin)	YES	NO					

Does your child take medication? ___NO ___YES (please list)

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips and after school activities. I authorize the school nurse to communicate with my child’s health care provider and my health care provider to reply as needed regarding my child’s care.

Parent/Guardian Signature _____ **Date** _____