Emergency Care Form for the 2015–16 School Year

Pittsburgh Public Schools | EXCELLENCE FOR ALL

The Pathway to the Promise.™

Please print clearly. Answer ALL questions and return form to your child's school.

Student's Last Name: ____________ Student's First Name: ____________ Middle: ____________

Other Last Name: ____________ Home Phone: ____________

Street Address: ____________ Zip Code: ____________

Gender: ________ Date of Birth (Month/Day/Year): ____________ Grade: ______ School: ____________

Student Resides With

Check all that apply. Please PRINT name(s) and phone number(s) where individual(s) can be reached during the day.

☐ Mother's Name: ____________ Phone: ____________
☐ Home ☐ Cell ☐ Work ☐ Other
Email Address: ____________
☐ *This individual is authorized to pick up the above student in an emergency situation.*

☐ Father's Name: ____________ Phone: ____________
☐ Home ☐ Cell ☐ Work ☐ Other
Email Address: ____________
☐ *This individual is authorized to pick up the above student in an emergency situation.*

☐ Guardian's Name: ____________ Phone: ____________
☐ Home ☐ Cell ☐ Work ☐ Other
Email Address: ____________
☐ *This individual is authorized to pick up the above student in an emergency situation.*

Emergency Contacts

In cases of illness or injury, when neither parent/guardian can be reached, PRINT name(s) of individual(s) who should be contacted. By providing this information, you are giving permission for the person or persons listed below to be contacted in case of an emergency.

☐ Name 1: ____________ Phone: ____________
☐ Home ☐ Cell ☐ Work ☐ Other
Email Address: ____________
☐ *This individual is authorized to pick up the above student in an emergency situation.*

☐ Name 2: ____________ Phone: ____________
☐ Home ☐ Cell ☐ Work ☐ Other
Email Address: ____________
☐ *This individual is authorized to pick up the above student in an emergency situation.*

☐ Name 3: ____________ Phone: ____________
☐ Home ☐ Cell ☐ Work ☐ Other
Email Address: ____________
☐ *This individual is authorized to pick up the above student in an emergency situation.*

Please turn over and complete page 2.

The Pittsburgh Public Schools (PPS) does not discriminate on the basis of race, color, national origin, sex, disability or age in its programs, activities or employment and provides equal access to the Boy Scouts and other designated youth groups. Inquiries may be directed to the Title IX Coordinator or the Section 504/ADA Title II Coordinator at 341 S. Bellefield Avenue, Pittsburgh, PA 15213 or 412.529.HELP (4357).

Health Information

If additional room is needed for responses to the items below, please use the space at the bottom of this form.

Check any of the following health condition(s) that your child may have: ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Allergies (Drugs/Food)

Other condition(s): ______________________________

List allergies to drugs/food: ______________________________

Please list ALL medications your child is presently taking: ______________________________

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

Recommended Vaccines

It is recommended that all children who did not have chickenpox disease get a second chickenpox vaccine. It is also recommended that all children in grades 7–12 get a Tdap vaccine and a Menactra (meningitis) vaccine.

Date of second chickenpox vaccine: ______________ **OR** My child had chickenpox disease at age/date: ______________

Date of Tdap vaccine: ______________ Date of Meningitis vaccine: ______________

State Required Physical

The Commonwealth of Pennsylvania mandates that all students have physical examinations in grades K–1, 6 and 9. These will be provided to your child free of charge, or the examination may be done by your family physician or healthcare provider. If your child is in grades K–1, 6 or 9, please answer both statements below:

1. I want my child's physical examination to be completed by the School District. ☐ Yes ☐ No
2. 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 October 14 of this school year or within one 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 Number: ______________________

Consent for Treatment of Child

In addition to First Aid, the School Nurse Practitioner 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 Medication)

Ibuprofen: ☐ Yes ☐ No (Advil/Motrin)

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.): ______________________________

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