THE SCHOOL DISTRICT OF
PHILADELPHIA

Student Emergency /Medical Information

Last Name:_____ First Name:_____ DOB: _____

School: St. Matthew 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_____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	**YES**	**NO**
Ibuprofen (Advil, Motrin)	**YES**	**NO**

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: Food substitution requires a new order yearly from a health care provider: _____

Other Health Problems: _____

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**_____

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