



# 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. _____	_____

Child's Doctor/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Medical Insurance:** MA \_\_\_ CHIP \_\_\_ Private \_\_\_  
 Insurance company name: \_\_\_\_\_ Policy Number \_\_\_\_\_

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

The emergency medical and/or dental care, including administration of emergency medications including stock Albuterol inhalers and EpiPens, which may be necessary to preserve the life of my child or to prevent impairment of their health in the event that time does not permit obtaining my personal consent for such care. I understand that I will be contacted as soon as possible, and will assume responsibility for giving permission for on-going care.

Parent's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 \_\_\_\_\_

Revised S-865 (06/2024)

**OPTIONAL**

**Non-Aerosol Topical Sunscreen Use at School**

Parents/guardians may choose to supply their child with **non-aerosol topical sunscreen**, if it is approved by the U.S. Food and Drug Administration. In order for a student to apply sunscreen during school hours, at a school-sponsored activity, or while under the supervision of school personnel, the parent/guardian must complete the attestations below.

***Parent/Guardian Attestation***

- By signing below, you confirm that you understand that the school is not responsible for ensuring that the sunscreen is applied by the student.
- By signing below, you confirm that the student has demonstrated that they are able to self-apply the sunscreen.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The school may cancel or restrict the possession, application, or use of a non-aerosol topical sunscreen product by a student if any of the following occurs:

- The student fails to comply with school rules concerning the possession, application, or use of the non-aerosol topical sunscreen product.
- The student shows an unwillingness or inability to safeguard the non-aerosol topical sunscreen product from access by other students.

If a school cancels or restricts the possession, application, or use of a non-aerosol topical sunscreen product by a student, the school shall provide written notice of the cancellation or restriction to the student's parent/guardian.