Pittsburgh Public Schools
Emergency Care Form
2024 – 2025 School Year

Rev. 05-2024

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

Student's Last Name	Student's First Name		Middle
Street Address		Zip Code	Home Phone
Gender (Check One) ☐ Male ☐ Female ☐ Non-Binary	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/Parent Name _____ _____
Phone Number ☐Home ☐Cell ☐Work ☐Other

Email address 1:_____ Email address 2:_____

☐Father/Parent Name _____ _____
Phone Number ☐Home ☐Cell ☐Work ☐Other

Email address 1:_____ Email address 2:_____

☐Guardian Name _____ _____
Phone Number ☐Home ☐Cell ☐Work ☐Other

Email address 1:_____ Email address 2:_____

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 Number ☐Home ☐Cell ☐Work ☐Other

Address:_____

Name 2: _____ _____
Phone Number ☐Home ☐Cell ☐Work ☐Other

Address:_____

Other important information or telephone numbers for emergency contact: _____

(Please turn over to complete Page 2)

Health Information

If additional room is needed for responses to the items below, please use the space provided 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: _____

_____

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

Required Vaccines

It is required that all children in grades 7 & 12 get a Tdap vaccine and Meningitis vaccine. Has your child received these vaccines? ☐ Yes ☐ No
If **No**, please provide proof that your child has received theses vaccines to prevent your child from being excluded from school.

Provision of School Health Services and Mandated School Health Services

The Commonwealth of Pennsylvania dictates that all students have mandated physical examinations in grades K/1, 6 and 9, and mandated screenings (i.e. BMI, Hearing, Vision, Scoliosis) in all or select grades. In addition, the Commonwealth of Pennsylvania dictates that all students have mandated dental examinations and screenings upon original entry into school, grades K/1, 3, and 7.

These examinations will be provided to your child free of charge by the district. A private health and/or dental examination directed at the parents'/guardians' request and expense is acceptable. The District will accept reports of privately conducted physical and dental examinations completed within one (1) year prior to a student's entry into the grade where an exam is required.

Students may be exempted from such examination or screening if it is contrary to the parent's/guardian's religious beliefs. This must be communicated *in writing* to the school nurse and dental hygienist by the parent/guardian.

Consent to Obtain Health Records

I give consent for the school nurse/school nurse practitioner to obtain immunization information and/or a copy of the last physical examination from my child's physician. ☐ Yes ☐ No

Physician's Name _____ **Phone** _____

Consent for Treatment of Child

In addition to First Aid, the School Nurse/School Nurse Practitioner may treat my child with the following. Check Yes or No for each:

Tylenol ☐ Yes ☐ No (Acetaminophen)	Antacid ☐ Yes ☐ No (Tums, heart burn, etc.)	Benadryl ☐ Yes ☐ No (Allergy medication)	Ibuprofen ☐ Yes ☐ No (Advil/Motrin)

I give my consent to the school nurse/school nurse practitioner to carry out ALL of those items indicated by "Yes" responses above. I also hereby verify that the information provided on this form is true and correct to the best of my knowledge, information and belief. I understand that false statements may be subject to penalties of 18 Pa. C.S.A. §4904.

_____ _____

Parent/Guardian Signature (Full Name) **Date**

Additional Information (Medical conditions, allergies, etc.)

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