EMERGENCY CARE INFORMATION FORM

PA Leadership Charter School
1332 Enterprise Drive
West Chester, PA 19380

Phone: 610.701.3333
Fax: 610.701.3339
www.palcs.org

_____ _____ _____ _____ M___ F___ _____
Student's Last Name | Student's First Name | M.I. | Grade | Gender | DOB

Street: _____ City:_____ Zip:_____ Primary Phone:(_____)_____

Child Lives with: ☐Both Parents ☐Parent 1 ☐Parent 2 ☐Guardian ☐Other_____

Parent 1's name:_____ Primary Phone: (____)_____ Alternate Phone: (____)_____

Occupation:_____ E-mail: _____ Alternate Phone: (____)_____

Parent 2's name: _____ Primary Phone: (____)_____ Alternate Phone: (____)_____

Occupation:_____ E-mail: _____ Alternate Phone: (____)_____

Guardian's name: _____ Primary Phone: (____)_____ Alternate Phone: (____)_____

Occupation: _____ E-mail: _____ Alternate Phone: (____)_____

In case of an emergency when parent/guardian cannot be contacted, I authorize the following individuals to be notified and give them permission to pick up my child:

Name: _____ Relationship:_____ (____)_____ (____)_____
Primary Phone | Alternate Phone

Name: _____ Relationship:_____ (____)_____ (____)_____
Primary Phone | Alternate Phone

Name:_____ Relationship: _____ (____)_____ (____)_____
Primary Phone | Alternate Phone

_____

In case of an emergency and it is necessary to call a physician or dentist, please contact:

_____ at (_____)_____ _____ at (____) _____
Physician's name | Physician's phone number | Dentist's name | Dentist's phone number

Student's Last Name: _____ **Student's First Name:** _____

Insurance Information:

☐ No health insurance ☐ HMO ☐ Other:_____

☐ Medicaid: (provide Medicaid number)_____

Insurance Group Name:_____ Policy Number: _____

List any known illnesses or allergies: _____

Please circle all that apply:

Asthma	Cardiovascular	Diabetes	Seizure Disorder
Gastrointestinal	Migraines	Orthopedic	Other _____

List the names and reasons for medications your child is currently receiving:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

****Parents/Guardians are responsible for providing the School Nurse or designated employee with <u>ALL</u> prescription and/or non-prescription medications needed for their child while they attend a PALCS campus, event or field trip.**

****** <u>EACH PRESCRIPTION and/or NON-PRESCRIPTION medication must be packaged in its original container and accompanied by a physician's order.</u> Medications must be labeled with their child's name and the dates and instructions for use. In addition, written parent authorization must accompany the medication.**

STUDENTS ATTENDING USP OR CPFA: I give the School Nurse or designated employee permission to administer the following over the counter medications according to package directions if needed:

<u>PLEASE INITIAL ALL THAT APPLY</u>: **Tylenol _____ Ibuprofen _____ Tums_____ Benadryl _____**

For life threatening allergic reactions injectable adrenaline (EPI-PEN) will be administered*

If your child requires an **<u>EPI-PEN</u>** for the treatment of a **<u>known allergy</u>** and they attend a PALCS campus or PALCS event, it is the parent/guardian responsibility to provide the School Nurse with an EPI-PEN and physician orders for usage.

In the event of a medical emergency involving the student, the Pennsylvania Leadership Charter School (PALCS) will attempt to reach the parent/guardian or one of the people listed as an emergency contact. If none of these people can be reached, PALCS personnel have my permission to use discretion in securing medical aid for my child.

It is understood that PALCS, any sponsoring district or authority, or their respective officers, agents, and employees will not be responsible for the expense incurred. Further, I agree to release and hold harmless all such parties from all causes, liabilities, damages, claims, demands or losses whatsoever related to the medical condition of the student allowed by law.

I understand and agree to the release.

Parent signature: _____ Date: _____

Guardian signature: _____ Date: _____