



FRANKFORD FRIENDS SCHOOL

Parent/Guardian Emergency Contact Form 2017-2018

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Health Insurance Carrier (please write on line above) Policy # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Parent/Guardian 1: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian 2: \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact #1: \_\_\_\_\_

*(other than parent or guardian)*

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact #2: \_\_\_\_\_

*(other than parent or guardian)*

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Medical Conditions**

Please list below any regular medications your child takes and any serious medical conditions that could inhibit activity in regular school activities, including physical education classes.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any allergies? YES NO

Please list any allergies and your child's reaction below:

Allergy	Reaction and Treatment

**Please Note: Parents/Guardians are responsible for providing updated health and emergency contact information to the school.**

Does your child use an epi-pen or other epinephrine injector? YES NO

Does your child use an asthma inhaler? YES NO

If your child uses an asthma inhaler, is s/he qualified and able to self-administer? YES NO

**Acknowledgment of Policies for Dispensing Prescription Medications**

I have read and acknowledge Frankford Friends School’s policies on prescription medications and asthma inhalers. I understand that to dispense prescription medications, Frankford Friends School requires the “Request for Administration of Medication, Treatments, or Use of Equipment” to be completed and signed by both the parent and the health professional. Frankford Friends School and the school’s employees are held harmless of any responsibility for the benefits or consequences of the prescribed medication and the school bears no responsibility for ensuring that the medication is taken.

\_\_\_\_\_  
Parent’s/Guardian’s signature

\_\_\_\_\_  
Date

**Acknowledgment of Policies for a Life-threatening Situation or Medical Emergency**

In the event of a life-threatening situation or what the school deems to be a medical emergency, I understand the school will call 911 and request an ambulance or police transport to a hospital, the location of which is at the discretion of the EMTs, for emergency treatment. I further understand the school will make every effort to contact me directly before transport. If the situation is not life-threatening or what the school deems to be a medical emergency, but other medical attention is needed, I understand that it will be necessary to have the student picked up by a parent, guardian, or other approved designee.

\_\_\_\_\_  
Parent’s/Guardian’s signature

\_\_\_\_\_  
Date

**Parent/Guardian Consent to Dispense Over-the-Counter Medications (if desired)**

Frankford Friends School’s policy is to dispense acetaminophen (Tylenol) or ibuprofen (Motrin) *only* for children 12 and over, provided by and with the signed permission of a parent/guardian. A note will be sent home for the parent/guardian, communicating what has been dispensed and when. If you wish the school to administer over-the-counter medication, please **return the medication with this form** and complete the information below:

Name of Medication	Dosage	When to Administer

\_\_\_\_\_  
Parent’s/Guardian’s signature

\_\_\_\_\_  
Date

**PLEASE COMPLETE PAGE 1 AND PAGE 2 OF THIS DOCUMENT  
AND RETURN TO SCHOOL BY JULY 30**