



**THE PINGRY SCHOOL AFTER-SCHOOL EMERGENCY TREATMENT FORM**

Student's Name: \_\_\_\_\_ Sex: M F (circle one)

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_ After School Activity: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Phone(home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Father's name: \_\_\_\_\_

Phone(home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Phone(home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Directions: Please answer the following questions about the student's medical history by circling the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Has the student ever had, or currently has:

a. Restriction from sports for a health-related problem? Y/N

b. A chronic or ongoing illness (such as diabetes or asthma)? Y/N

c. Any allergies to medications? Y/N

d. Any allergies to bee stings, pollen, latex, or foods? Y/N

If yes, circle type of reaction:

Rash Hives Breathing or other anaphylactic reaction

e. Any medications (Epipen, Inhaler, etc.) needed for severe allergy or health conditions? (List below) Y/N

Explain all "yes" answers here (include relevant dates):

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

Please list all emergency medications that will be provided for After-School use:

Medication                      Dosage                      Frequency                      Reason

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

I authorize the Pingry After-School Staff to provide any emergency care or treatment necessary for the health and well-being of my child.

In case of emergency, The Pingry School is authorized to take my child to a doctor/hospital for treatment as necessary if the emergency contacts cannot be reached.

Parent/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_