Breakthrough of Greater Philadelphia
34 West Coulter St, Philadelphia, PA, US 19144

Full Name of Student:
Address:

Student DOB:
Student Phone #:

Name of Emergency Contact:
Relationship to Student:
Address:
Employer Name:
Employer Address:

Home Phone #
Cell Phone #:
Work Phone #
Best Way to Contact You:

Name of Emergency Contact #2:
Relationship to Student:
Address:
Employer Name:
Employer Address:

Home Phone #
Cell Phone #:
Work Phone #:
Best Way to Contact You:

MEDICAL INFORMATION

Does this student have an ongoing medical, psychological, or behavioral condition? Please Explain

Does this student take regular medication(s)? Please identify:

Does this student have allergies to medications, foods, insects, etc.?

Date of Last Tetanus Booster:

Insurance Company:
Policy Number:
Name of Primary Care Physician:
Physician Address:
Physician Phone #:
Medicaid (Medical Assistance):

CIRCLE ONE:

Breakthrough staff must reach a contact before administering any medication

Breakthrough staff may administer medication first, and then reach a contact

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IN THE EVENT OF AN INJURY OR ILLNESS TO MY CHILD REQUIRING MEDICAL ATTENTION, I UNDERSTAND THAT ALTHOUGH THE STAFF OF BREAKTHROUGH OF GREATER PHILADELPHIA WILL MAKE EVERY EFFORT WILL BE MADE TO CONTACT THE PRIMARY EMERGENCY CONTACT(S) TO RECEIVE SPECIFIC AUTHORIZATION BEFORE ANY TREATMENT IS PROVIDED, THE FIRST PRIORITY WILL BE ENSURING THE HEALTH AND SAFETY OF MY CHILD.

IF EFFORTS TO REACH PRIMARY CONTACT(S) ARE UNSUCCESSFUL, I GRANT PERMISSION TO BREAKTHROUGH STAFF TO ARRANGE FOR MEDICAL TRANSPORTATION OF AND TREATMENT FOR MY CHILD, INCLUDING WITHOUT LIMITATION IMAGING STUDIES, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS AND TREATMENT AND EMERGENCY HOSPITAL CARE THAT APPEAR TO BE NECESSARY OR DESIRABLE FOR THE PROTECTION OF THE HEALTH OR LIFE OF MY MINOR CHILD, NAMED ABOVE. IN THE EVENT THAT BREAKTHROUGH STAFF ACCOMPANIED MY CHILD TO A MEDICAL FACILITY FOR TREATMENT,

I GRANT PERMISSION FOR BREAKTHROUGH STAFF TO RELEASE MY CHILD TO THE FOLLOWING INDIVIDUALS IN ADDITION TO THE PRIMARY AND EMERGENCY CONTACTS INDICATED ON THIS FORM:

PARENT OR GUARDIAN'S NAME
AND SIGNATURE

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THESE GUIDELINES ARE DESIGNED FOR THE SAFETY OF YOUR CHILD AND ARE STRICTLY ENFORCED. IF YOU HAVE ANY QUESTIONS/CONCERNS PLEASE CONTACT THE SITE DIRECTOR

THE SITE DIRECTOR SHALL HAVE AUTHORIZATION TO DETERMINE PROCEDURES FOR STAFF DEVELOPMENT IN MONITORING STUDENTS WHO SELF-ADMINISTER MEDICATION AND EQUIPMENT FOR DIABETES, ASTHMA AND FOR SEVERE ALLERGIC REACTIONS AND REVIEWING STUDENTS' ABILITY TO SELF-ADMINISTER SAME. DIABETIC AND ASTHMATIC STUDENTS AND THOSE SUBJECT TO SEVERE ALLERGIC REACTIONS OF SCHOOL AGE MAY POSSESS ON THEIR PERSONS, INCLUDING BOOK BAGS AND HANDBAGS, ALL NECESSARY SUPPLIES, EQUIPMENT AND PRESCRIBED MEDICATION TO PERFORM SELF-MONITORING AND TREATMENT IF CERTAIN CRITERIA ARE MET FOR SELF-ADMINISTRATION IN ADDITION TO PARENTAL AND MEDICAL PROVIDER DOCUMENTATION.

A STUDENT WITH ASTHMA SHALL BE PERMITTED TO USE AN ASTHMA INHALER AND A STUDENT WITH DIABETES SHALL BE PERMITTED TO PERFORM BLOOD GLUCOSE CHECKS, TREAT HYPOGLYCEMIA AND HYPERGLYCEMIA AND OTHERWISE ATTEND TO THE CARE AND MANAGEMENT OF HIS OR HER DIABETES IN THE CLASSROOM IN ANY AREA OF THE SCHOOL OR SCHOOL GROUNDS AND AT ANY SCHOOL-RELATED ACTIVITY IF REQUESTED BY THE PARENT OR GUARDIAN. A STUDENT WITH MEDICALLY CERTIFIED SEVERE AND POSSIBLY LIFE-THREATENING ALLERGIC REACTION(S) AND OF SCHOOL AGE MAY POSSESS AN EPINEPHRINE AUTO-INJECTOR ON THEIR PERSONS, INCLUDING BOOK BAGS AND HANDBAGS, TO PERFORM TREATMENT FOR AN ALLERGIC REACTION.

SUCH REQUEST MUST BE IN THE FORM OF AN ASTHMA MEDICAL MANAGEMENT PLAN (AMMP) OR DIABETES MEDICAL MANAGEMENT PLAN (DMMP) OR HEALTH REQUEST FORM FOR EPI-PEN USE, RESPECTIVELY, EACH OF WHICH INCLUDES A STATEMENT FROM THE TREATING PHYSICIAN, CERTIFIED REGISTERED NURSE PRACTITIONER OR PHYSICIAN ASSISTANT INDICATING THAT THE STUDENT HAS SUCCESSFULLY DEMONSTRATED CAPABILITY OF INDEPENDENT MONITORING AND RESPONSIBLE BEHAVIOR IN SELF- ADMINISTERING TREATMENT OR PRESCRIBED MEDICATION. AS PART OF A STUDENT'S RESPONSIBLE BEHAVIOR, THE STUDENT IS TO NOTIFY THE SITE DIRECTOR OR DEAN OF STUDENTS IMMEDIATELY FOLLOWING EACH USE OF MEDICATION OR EQUIPMENT FOR THE STUDENT'S ASTHMA OR DIABETES RELATED CONDITION.

I UNDERSTAND THAT MY CHILD IS RESTRICTED FROM MAKING MEDICATION OR ANY MEDICAL EQUIPMENT AVAILABLE TO OTHER STUDENTS, AND THAT MY CHILD IS PROHIBITED FROM USING ANOTHER CHILD'S MEDICATION. THE STUDENT'S PRIVILEGE TO SELF-ADMINISTER MEDICATION OR EQUIPMENT MAY BE REVOKED OR RESTRICTED IF THE STUDENT ABUSES OR IGNORES BREAKTHROUGH POLICIES.

PARENT OR GUARDIAN'S NAME
AND SIGNATURE