PLEASE COMPLETE MEDICAL INFORMATION FOR THE SCHOOL NURSE AND SIGN BELOW 2023-24

Student's Name Last ______ **First** ______ **Grade (23-24)** ______

Student's Physician ______ **Phone** ______

Student's Dentist ______ **Phone** ______

In case of emergency, may the student's physician or dentist be contacted if the parent is unavailable? ______

Current Medications and dosages (home or school) ______

Please describe the reaction and treatment if your child has a severe allergic reaction to the following:

Bee Sting or other stinging insect: ______

Reaction: ______ **Treatment:** ______

Food allergies:

Reaction: ______ **Treatment:** ______

Contact Ms. Wood, Director of Food Service, for special dietary needs 412-221-4542 ext 279.

Other severe allergies: ______

Reaction: ______ **Treatment:** ______

If your child has a severe allergy requiring the use of an Epi Pen or Benadryl, you must submit a written physician's order, parental or guardian's written consent and the medication for treatment following a severe allergic reaction. Please review school district medication administration policy #210 or contact the school nurse to receive a medication administration form.

Does your child have a history of any of the health conditions listed below? Please explain and list any treatment or medications taken for the health condition(s).

Condition	Yes	No	Explain	Condition	Yes	No	Explain
Seasonal Allergies	Yes	No	Explain	Eyesight Issues	Yes	No	Explain
Asthma	Yes	No	Explain	Fainting	Yes	No	Explain
ADD/ADHD	Yes	No	Explain	Fractures, sprains	Yes	No	Explain
Anemia or Bleeding issues	Yes	No	Explain	Sickle cell disease	Yes	No	Explain
Cardiovascular conditions	Yes	No	Explain	Gastrointestinal disorders	Yes	No	Explain
Cerebral Palsy	Yes	No	Explain	Hepatitis	Yes	No	Explain
Color deficit	Yes	No	Explain	Mental Health Issues	Yes	No	Explain
Concussions	Yes	No	Explain	Neurological Disorders	Yes	No	Explain
Cystic Fibrosis	Yes	No	Explain	Scoliosis	Yes	No	Explain
Diabetes Type 1 or 2	Yes	No	Explain	Hearing Problem	Yes	No	Explain
Autism Spectrum Disorder	Yes	No	Explain	Arthritis/Rheumatic disease	Yes	No	Explain
Eating Disorder	Yes	No	Explain	Tourette Syndrome	Yes	No	Explain
Epilepsy or Seizure Disorder	Yes	No	Explain	Other Health Problems	Yes	No	Explain

My child (K-2) may have a throat lozenge for a cough or sore throat.	Yes____	No ____
My child (grade 6 - 12 only) may take **acetaminophen** (example: Tylenol).	Yes____	No ____
My child (grade 6 - 12 only) may take **ibuprofen** (example: Motrin or Advil).	Yes____	No ____
My child (grade 6 - 12 only) may take **Tums**.	Yes____	No ____

In an emergency, the E.M.S. will take the student to the nearest hospital. Every effort will be made to contact the parent/guardian prior to transport. If you prefer other arrangements, please state: ______________________________

No treatment except life -saving procedures will be given at the hospital without consent of parent, authorized relative or guardian.

Per federal guidance, student medical records, maintained by the nurses' office, are considered educational records and will be shared with staff who the district determines have a legitimate educational interest in the information and a need to know medical information to protect the safety and health of the student. Once provided to the District, specific parental consent will not be sought to share information on a need to know basis. Parental requests to maintain the confidentiality of specific medical information must be made in writing to the nurses' office. **Requests for complete confidentiality of medical information will be granted at the discretion of the nurse. These requests will be granted unless dangerous to the student.**

Parent/Guardian Signature ______________________ **Date:** ______________

Annual Health Office Student Emergency Information for School Year 2023-24

(This information must be updated by parent/guardian(s) each school year)

DIRECTIONS: Parent/Guardian please complete all areas (print) on both sides, sign, date, and return to school nurse.

Student's Legal Name: Last	First	Middle	**Grade**	**Date of Birth**: Month/Day/Year ____/____/_____

Student Lives With: (If not parents, provide full name/relationship of guardian)	**Student's home phone**:
Student's Residence Address: Street	Student's Mailing Address (if different than residence address)
City State Zip	City State Zip

Contact and Emergency Information

Parent/Guardian Name (Please include address only if different from student) Mother/Guardian Name: Address (If different) E-mail address : Occupation: Occupation address:	Home Phone Cell Phone Work Phone	**Authorized to Pickup** **Yes ( )** **No ( )**
Father/Guardian Name : (Please include address only if different from student) Address (If different) E-mail address : Occupation: Occupation address:	Home Phone Cell Phone Work Phone	**Yes ( )** **No ( )**
Other (Name/Relationship) If lives with someone other than mother or father: Address (If different) E-mail address: Occupation: Occupation address:	Home Phone Cell Phone Work Phone	**Yes ( )** **No ( )**

If parent/guardian cannot be reached, please list persons below that may be contacted in case of an illness or emergency. Please check if the person is also authorized to pick the student up from school.

Emergency Contact(Name/Relationship)	Home Phone Cell Phone/Pager	**Authorized Pickup** **Yes ( )No ( )**
Emergency Contact(Name/Relationship)	Home Phone Cell Phone/Pager	**Authorized Pickup** **Yes ( )No ( )**

Legal Custody Information: Please explain any special instructions here that the school nurse should know concerning custody issues:

Please complete both sides of this form.