**Student Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Birth Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**ANTIETAM SCHOOL DISTRICT HEALTH INFORMATION- 2017/2018**

**ST. CATHARINE OF SIENA SCHOOL**

**Last First**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade\_\_\_\_\_\_\_\_Homeroom Teacher\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male\_\_\_\_Female\_\_\_\_

**RESIDES WITH**: BOTH PARENTS FATHER MOTHER GUARDIAN

**Father/Guardian** *Check number to call first* **Mother/Guardian:**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_** NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Call 1st** HOME #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Call 1st**

WORK#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Call 1st** WORK #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Call 1st**

CELL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **C all 1st** CELL #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Call 1st**

2-LOCALcontactswhowillassume TEMPORARY careifparent/guardian CANNOT bereached:

**Name Relationship Phone #'s**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give the school nurse permission to administer the following over the counter medications as needed: Tylenol, Ibuprofen, Chloraseptic lozenge/throat spray, Tums, and Benadryl - generic medications may be substituted.

\*Ibuprofen is limited to 2 doses weekly without written physician permission

*\*\*For life threatening allergic reactions injectable adrenaline (Epi-Pen) will be administered\*\**

**I GIVE PERMISSION: YES NO**

Is your child **ALLERGIC** to: **BEE stings?** YES NO **INSECT bites?** YE**S** NO **Latex?** YES NO

If **YES, describe reaction and treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is your child **ALLERGIC** to: **PEANUTS?** YES NO **TREE NUTS?** YES NO

Is your child **ALLERGIC** to any other **FOOD/SUBSTANCE?** YES NO

If **YES**, please list food and reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**TREATMENT FOR REACTION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If **YES**, will your child be eating food served in the cafeteria**?** YES NO

Is your child able to self-monitor to avoid exposure to theirfood allergen**?** YES NO

**DOES YOUR CHILD REQUIRE AN EPI-PEN?** YES NO

**\*\*\*\*If your child requires an Epi-pen for the treatment of a known allergy, it is the parent/guardians responsibility to provide the school nurse with the Epi-pen and physician orders for usage.**

PLEASE COMPLETE THE FOLLOWING SECTION RELATING TO MEDICATIONS YOUR CHILD RECEIVES

Daily or as needed, including medications taken at home. If required at school, must have medication order from physician.

Medication Name Time Reason for Use

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*PLEASE COMPLETE BOTH SIDES\*\*\***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CHECK ALL THAT APPLY** | **YES** | **NO** |  | **YES** | **NO** |
| Arthritis/Rheumatic Disease |  |  | Eating Disorder |  |  |
| Asthma |  |  | Emotional Problems |  |  |
| **Requires Inhaler at school(\*will need a doctor’s order)** | **\*** |  | Family History of Sudden Death |  |  |
| Attention Deficit Disorder/Hyperactivity |  |  | Hearing Loss |  |  |
| Bleeding Disorder |  |  | History of Fainting |  |  |
| Cancer |  |  | Orthopedic Problems |  |  |
| Cardiovascular Condition/ Prolonged QT syndrome |  |  | Seizure Disorder |  |  |
| Cerebral Palsy |  |  | Sickle Cell Disease |  |  |
| Cystic Fibrosis |  |  | Spina Bifida |  |  |
| Diabetes Type I |  |  | Tourette’s Syndrome |  |  |
| Diabetes Type II |  |  | Vision Concerns |  |  |
| Digestive Disorders (IBS/GERD/CROHN's) |  |  | **MY CHILD WEARS:** *(please circle yes/no)*  Glasses-YES NO  Contact lens- YES NO  Hearing Aides- YES NO |  |  |

**ARE THERE ANY OTHER HEALTH CONCERNS THE SCHOOL NURSE SHOULD BE AWARE OF?**

**List siblings or any other district students living in same house:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(name & grade) (name & grade) (name & grade) (name & grade)

**\*All Ktgn, 1ST, 3RD, 6TH, 7TH, and 11THgradestudents- MUST COMPLETE!**

**The state of Pennsylvania mandates all students entering school, in Kindergarten /1st grade, 6th grade or 11th grade have a physical exam and all students entering school, in Kindergarten /1st grade, 3rd grade or 7th grade receive a dental exam.**

It is recommended that your family dentist/physician do this examination, as he or she can assist you in any treatments or corrections that may be necessary. In addition, your child maybe more comfortable in a setting he or she is familiar with. An examination performed any time after September 1, 2016 is acceptable. The private dental/physical form is available on the school website or in the nurse's office. Please return the completed private dental/physical form by September 30, 2017. If you prefer to have your child examined by the school dentist/physician a basic dental or physical examination will be done during this school year.

yes no I prefer to have my family dentist/physician do the exam and will return the completed form by September 30, 2017. I understand if the form is not received by the school nurse my son/daughter will be scheduled for a school dental/physical exam.

yes no I prefer to have the school dentist/physician examine my child.

yes no I wish to attend the physical/dental exam.

\*\* Pleaseprovide immunization updates for ALL students\*\*

In case of an emergency, when parents or emergency contacts cannot be reached, I give permission to school

authorities to use their judgment in obtaining care for this student. Any cost incurred will be the responsibility of the parent/guardian.

**I HAVE REVIEWED/COMPLETED BOTH SIDES OF THIS CARD AND AGREE TO UPDATE THE SCHOOL NURSE WITH ANY CHANGES.**

Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_