## Health Information

If additional room is needed for responses to the items below, please use the space provided at the bottom of this form.

Check any of the following health condition(s) that your child may have: ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Allergies (Drugs /Food)

☐ Other Condition(s): _____

List allergies to drugs/food: _____

Please list ALL medications your child is presently taking: _____

_____

Does your child have health care insurance (CHIP, Medicaid or Private) coverage? ☐ Yes ☐ No

## Required Vaccines

It is required that all children in grades 7-12 get a Tdap vaccine and a Menactra (meningitis MCV4) vaccine. Has your child received these vaccines? ☐ Yes ☐ No If no, to prevent your child from being excluded from school, please provide proof that your child has received theses vaccines.

## State Required Physical

The Commonwealth of Pennsylvania mandates that all students have physical examinations in grades K-1, 6 and 9. These will be provided to your child free of charge, or the examination may be done by your family physician or health care provider. If Your Child is in Grades K-1, 6 or 9, please answer both statements below:

1. I want my child's physical examination to be completed by the School District. ☐ Yes ☐ No
2. I will have my child's physical examination to be completed by our family physician or health care provider and sent to the School Nurse. ☐ Yes ☐ No

NOTE: Please send record of physical examination to the School Nurse by OCTOBER 31, 2016.

## Consent to Obtain Health Records

I give consent for the school nurse/school nurse practitioner to obtain immunization information and/or a copy of the last physical from my child's physician. ☐ Yes ☐ No

Physician's Name _____ Phone No. _____

## Consent for Treatment of Child

In addition to First Aid, the School Nurse/School Nurse Practitioner may treat my child with the following. Check Yes or No for each:

| | | | |
|---|---|---|---|
| Tylenol ☐ Yes ☐ No (Acetaminophen) | Antacid ☐ Yes ☐ No (Stomach ache) | Benadryl ☐ Yes ☐ No (Allergy medication) | Ibuprofen ☐ Yes ☐ No (Advil/Motrin) |

By my signature, I give my consent for the school nurse/school nurse practitioner to carry out ALL responses indicated by "Yes".

_____ _____

Parent/Guardian Signature (Full Name) Date

## Additional Information (Medical conditions, allergies, etc.)

_____

_____

_____

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**☐ Other Condition(s):** _____

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_____ _____

**Parent/Guardian Signature (Full Name)** **Date**

## Additional Information (Medical conditions, allergies, etc.)

_____

_____

_____