Last First

**NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**BIRTH DATE**\_\_\_\_/\_\_\_\_/\_\_\_\_\_

GRADE\_\_\_\_\_\_\_ HOME ROOM #/TEACHER\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MALE \_\_\_ FEMALE\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
RESIDES WITH: BOTH PARENTS: FATHER: MOTHER:  GUARDIAN: 

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

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** 1st**

WORK #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** 1st**

CELL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** 1st**

**\*\*Parent/Guardian EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** 1st**

WORK #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** 1st**

CELL # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 1st**

IN THE EVENT THE PARENT/GUARDIAN CANNOT BE REACHED LIST 2 LOCAL CONTACTS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD:

**Name** **Relationship** **Phone #’s**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**STUDENT ALLERGIES**

Does your child have any medically diagnosed **FOOD/DRUG/SUBSTANCE ALLERGIES**? ** YES  NO**



**Describe ALLERGY:**

**Describe REACTION:**

**Describe TREATMENT:**

**Will your child need an Epi Pen at school?  YES  NO**

\*\*\*IF your child requires an Epi-pen for the treatment of a known allergy, it is the parent/guardian

responsibility to provide the school nurse with the Epi-pen, Allergy Action Plan, and physician orders for usage.

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**MEDICATION AT SCHOOL**

The nurse is the only person authorized to administer medications. All medication brought to school must be accompanied by an *Authorization for School Medication* *Administration Form* which must be completed in full. This form can be accessed at pjphs.org. Medication must be received in the original packaging with label including child name, medication name, dosage, prescribing physician, date, and directions for use.

I give the school nurse permission to administer the following over the counter medications as needed: Tylenol, Ibuprofen, Chloraseptic, Tums, and Benadryl. Generic medications may be substituted.

*(Ibuprofen is limited to 3 doses weekly without written physician permission)*

**I GIVE PERMISSION:  YES  NO**

*\*\*Emergency medications Epinephrine and/or Narcan may be administered in case of a life threatening emergency \*\**

|  |
| --- |
| I give the school nurse or designated employee permission to administer potassium iodide (KI tab) when instructed by the governor or public health official in the event of a radioactive emergency during school hours.  **I GIVE PERMISSION :  YES  NO** |

***Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*DATE*\_\_\_\_\_\_\_\_\_\_***

**WHAT MEDICATIONS DOES YOUR STUDENT TAKE AT HOME?**

Medication Name Time Reason for Use

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

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

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HEALTH CONDITIONS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CHECK ALL THAT CURRENTLY APPLY** | YES | NO |  | YES | NO |
| ARTHRITIS / RHEUMATIC DISEASE |  |  | EATING DISORDER |  |  |
| ASTHMA |  |  | EMOTIONAL PROBLEMS |  |  |
| \*\*INHALER NEEDED AT SCHOOL? |  |  | HEARING LOSS |  |  |
| ATTENTION DEFICIT DISORDER / HYPERACTIVITY |  |  | HISTORY OF FAINTING |  |  |
| BLEEDING DISORDER |  |  | ORTHOPEDIC PROBLEMS |  |  |
| CANCER |  |  | SEIZURE DISORDER |  |  |
| CARDIOVASCULAR CONDITION / PROLONGED QT SYNDROME |  |  | SICKLE CELL DISEASE |  |  |
| CEREBRAL PALSY |  |  | SPINA BIFIDA |  |  |
| CYSTIC FIBROSIS |  |  | TOURETTE'S SYNDROME |  |  |
| DIABETES TYPE l |  |  | VISION CONCERNS |  |  |
| DIABETES TYPE II |  |  | CONCUSSION(S) |  |  |
| DIGESTIVE DISORDERS (IBS/GERD/CROHN’S) |  |  | OTHER HEALTH CONCERNS |  |  |

\*\*If your child requires medication to treat asthma, complete the *Authorization for School Medication* form found on the website. Complete the ‘self-carry inhaler’ section if applicable and have form signed by physician and parent.

**BELOW PLEASE PROVIDE EXPLANATION OF MEDICAL CONDITION(S) CHECKED YES ABOVE:**

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| --- |
| **Parents of 11th Grade Students ONLY– State Requirement**  **Physical exam** (performed any time after July 1, 2022) **is due to health suite by September 30, 2023.**  I will be turning in my child’s most recent private physical exam **with updated immunizations**.(PIAA form accepted, but **copy of physician signed exam** **must be turned in to nurse –** please include immunization page)  I prefer to have the school physician assistant examine my child but will turn in immunizations.  I wish to attend the physical exam. yes no  *Any 11th grade student without a physical exam form after September 30, 2023 will receive a school physical to meet this PA State Mandate. You will be notified of the date for this exam.* |

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 both sides of this card and will inform the school nurses’ office with updates.

***Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*DATE*\_\_\_\_\_\_\_\_\_\_***