

Pope John Paul II High School
HEALTH/EMERGENCY INFORMATION

****2 Sided**

NAME _____ Last _____ First _____ 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 _____

NAME _____

HOME # _____ 1st

HOME # _____ 1st

WORK # _____ 1st

WORK # _____ 1st

CELL # _____ 1st

CELL # _____ 1st

**Parent/Guardian EMAIL _____

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. _____

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.

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 ***

Signature of Parent/Guardian: _____ **DATE** _____

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

**Pope John Paul II High School
HEALTH/EMERGENCY INFORMATION**

****2 Sided**

WHAT MEDICATIONS DOES YOUR STUDENT TAKE AT HOME?

Medication Name	Time	Reason for Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

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 I			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:

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** _____

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