Lincoln Intermediate Unit 12
Leadership • Expertise • Innovation

2025 - 2026 School Year

Health and Emergency Information for York Learning Center Health Rooms

Student's Name: _____
(Last) (First) (Middle)

Main Address: _____

Birth Date: _____School District: _____

Home Phone Number: _____

1. Parent/Guardian: _____ Cell Phone: _____

E-Mail Address: _____

Place of Employment: _____Phone: _____

2. Parent/Guardian: _____Cell Phone: _____

E-Mail Address: _____

Place of Employment: _____Phone: _____

Any Step Parent: _____Cell Phone: _____

Preferred Hospital: _____

Person to notify in case of emergency if Guardian not available: _____
(Name)

_____
(Relationship) (Address) (Phone Number)

People and pets that live in the home and their age: _____

_____

Primary Care Provider: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Dentist: _____ Phone: _____

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Student Name: _____

Health History

Medical Diagnoses or Surgeries: _____

_____

Allergies: _____

Any other instructions or information that school personnel should know in caring for your child:

_____

_____

List medications taken at **HOME:**

Name	Dosage	Times Taken

List medications or Treatments that will be taken at **SCHOOL**.

Name	Dosage	Times Taken

An order from the Doctor MUST be received before the medication can be administered. Medications must be sent to school in the original prescription bottle with the original label (not longer than a year old) and brought into school by a responsible adult. Only 30 days of medication can be at school at one time per Pennsylvania States Regulations. Fax # 717-718-5897.

Please contact the Health Room with any questions, issues or changes during the school year.

Susan Combs, RN, MSN, CSN; skcombs@iu12.org
Cindy Slenker, LPN; Lorie Myers, LPN (East Wing)
East Wing Phone: 717-718-5809 East Wing Fax: 717-718-5897
Marsha Snyder, LPN (West Wing)
West Wing Phone: 717- 718-5849 West Wing Fax: 717-718-5896

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Student Name: _____ Birth Date: _____

My child has my permission to be given the following medications for first aid treatment at school by the School Nurse or self-care with school personnel. Only **4 doses maximum every month** unless Doctor's order and medication provided by parent.

____ **Tylenol (Acetaminophen)** for mild pain/discomfort and/or temperature 100.4 degrees Fahrenheit or higher. Dose given per package instructions by weight.

____ **Benadryl (Diphenhydramine)** for rash, hives, or allergic reaction.

____ **Motrin (Ibuprofen)** for mild pain/discomfort and/or temperature 100.4 degrees Fahrenheit or higher. Dose given per package instructions by weight.

____ **Tums (Calcium Carbonate)** for indigestion or nausea.

____ **Cola Syrup** for nausea.

____ **Cough Drops** for sore throat and cough.

____ **Sore Throat Lozenges (Sucrets) or Sore Throat Lollipops** for sore throats.

____ **Oragel** for mouth sores.

____ **Eye Wash** drops for eye irritation.

____ Teeth Brushing

____ Nail Trimming

____ Change of clothes if needed and/or shower

____ **Vaseline (Petroleum Jelly)** for chapped lips, chapped skin, and/or diaper area protection.

____ **Antibiotic Ointment (Bacitracin)** for small open wound injuries to prevent infection.

____ **Hydrocortisone Cream 1%** to alleviate small skin areas of itching.

____ **Caldaryl Gel** for Poison Ivy Rash or mild itching.

____ **Aloe Vera Gel** for minor burns or sunburn.

____ **Antifungal Cream (Clotrimazole Cream)** for suspected skin ringworm or athlete's foot.

____ **Sunscreen Lotion**

____ Student needs assistance applying

____ Student able to safely apply themselves

Parent/Guardian Signature: _____ Date: _____

LINCOLN INTERMEDIATE UNIT12
INFORMATION RELEASE FORM

I hereby authorize LIU12 and the following organizations as marked to release information to and receive information from:

□	Children & Youth	***Please list all others below:***
□	Juvenile Probation	□ Primary Care Provider:
□	Mental Health/Intellectual & Developmental Disabilities	
□	Health Choices Management Unit	□ Medical Specialist:
□	Drug and Alcohol Program	
□	Service Access & Management (SAM)	□ Medical Specialist:
□	School District	
□	Lincoln Intermediate Unit	□ Dentist:
□	Community Care Behavioral Health (CCBH)	

From the record of: Student Name: _____ Date of Birth: _____

Address: _____City/State: _____Zip: _____School District: _____

The following information will be exchanged to assist professional personnel in helping my child in his/her educational placement and program (select all that apply):

□	Psychiatric / Psychological reports	□	Vocational skills assessment
□	Teacher observations / School records	□	Social History / Family Information
□	Progress Reports	□	Attendance Data
□	Medical Reports	□	Report Cards
□	Neurological Reports	□	Admission/Discharge Reports
□	IQ test scores, aptitude and achievement tests	□	Behavior Reports
□	Other:	□	Other:

This release is valid for *12 months* from the date of signature and may be revoked by notifying the LIU12 Supervisor in writing or witnessed verbally. **I have read this form carefully and understand what it means.**

_____ _____
Signature of Student (age 14 and above) Date

_____ _____ _____
Signature of Parent or Guardian (Relationship) Date

Verbal release of information *if applicable* (***requires signature from two witnesses): This section is to be used for consumers who are unable to provide a signature. We have witnessed that the consumer understands the nature of this release and has freely given his/her consent.

***Signature of Witness: _____ _____

In accordance with Pennsylvania Regulations: "This information has been disclosed to you from records whose confidentiality is protected by State Law. State regulations limit your right to make any further disclosure of this information without the prior written consent of the person to whom it pertains."