PLEASE COMPLETE MEDICAL INFORMATION FOR THE SCHOOL NURSE AND SIGN BELOW

Student's Name Last **First** **Grade**

Student's Physician **Phone**

Student's Dentist **Phone**

In case of emergency, may the student's physician or dentist be contacted if the parent is unavailable?

Current Medications and dosages (home or school)

Please describe the reaction and treatment if your child has a severe allergic reaction to the following:

Bee Sting or other stinging insect:

Reaction: **Treatment:**

Food allergies:

Reaction: **Treatment:**

Contact our Director of Food Service, for special dietary needs 412-221-4542 ext 279.

Other severe allergies:

Reaction: **Treatment:**

If your child has a severe allergy requiring the use of an Epi Pen or Benadryl, you must submit a written physician's order, parental or guardian's written consent and the medication for treatment following a severe allergic reaction. Please review school district medication administration policy #210 or contact the school nurse to receive a medication administration form.

Does your child have a history of any of the health conditions listed below? Please explain and list any treatment or medications taken for the health condition(s).

Seasonal Allergies Yes No Explain

Asthma Yes No Explain

ADD/ADHD Yes No Explain

Anemia or Bleeding issues Yes No Explain

Cardiovascular conditions Yes No Explain

Cerebral Palsy Yes No Explain

Color deficit Yes No Explain

Concussions Yes No Explain

Cystic Fibrosis Yes No Explain

Diabetes Type 1 or 2 Yes No Explain

Autism Spectrum Disorder Yes No Explain

Eating Disorder Yes No Explain

Epilepsy or Seizure Disorder Yes No Explain

Eyesight Issues Yes No Explain

Fainting Yes No Explain

Fractures, sprains Yes No Explain

Sickle cell disease Yes No Explain

Gastrointestinal disorders Yes No Explain

Hepatitis Yes No Explain

Mental Health Issues Yes No Explain

Neurological Disorders Yes No Explain

Scoliosis Yes No Explain

Hearing Problem Yes No Explain

Arthritis/Rheumatic disease Yes No Explain

Tourette Syndrome Yes No Explain

Other Health Problems Yes No Explain

My child (K-2) may have a pectin throat lozenge for a cough. Yes____ No ____

My child (grade 6 - 12 only) may take **acetaminophen** (example: Tylenol). Yes____ No ____

My child (grade 6 - 12 only) may take **ibuprofen** (example: Motrin or Advil). Yes____ No ____

My child (grade 6 - 12 only) may take **Tums**. Yes____ No ____

In an emergency, the E.M.S. will take the student to the nearest hospital. Every effort will be made to contact the parent/guardian prior to transport. If you prefer other arrangements, please state: _____
No treatment except life -saving procedures will be given at the hospital without consent of parent, authorized relative or guardian.

Per federal guidance, student medical records, maintained by the nurses' office, are considered educational records and will be shared with staff who the district determines have a legitimate educational interest in the information and a need to know medical information to protect the safety and health of the student. Once provided to the District, specific parental consent will not be sought to share information on a need to know basis. Parental requests to maintain the confidentiality of specific medical information must be made in writing to the nurses' office. **Requests for complete confidentiality of medical information will be granted at the discretion of the nurse. These requests will be granted unless dangerous to the student.**

Parent/Guardian Signature _____ **Date:** _____