

→ COMPLETE BOTH SIDES  
→ RETURN TO NURSE TOMORROW

**METHACTON SCHOOL DISTRICT  
STUDENT HEALTH FORM  
SCHOOL YEAR: 2026-2027**

**STUDENT NAME** \_\_\_\_\_ **ID#** \_\_\_\_\_

GRADE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ BUILDING \_\_\_\_\_  
GENDER \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

PARENT / GUARDIAN NAME: \_\_\_\_\_ CELL # \_\_\_\_\_

EMAIL \_\_\_\_\_ WORK # \_\_\_\_\_ HOME# \_\_\_\_\_

PARENT / GUARDIAN NAME: \_\_\_\_\_ CELL # \_\_\_\_\_

EMAIL \_\_\_\_\_ WORK # \_\_\_\_\_ HOME # \_\_\_\_\_

Child Lives with: (ie: mother, father, guardian, other) \_\_\_\_\_

Custody Information on File at School? \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_ N/A

Other Contacts Not Listed Above My Child May Be Released To:

**NAME & RELATIONSHIP (TO CHILD)**

**PHONE #**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Siblings in Methacton School District/ Grade: \_\_\_\_\_

I GIVE PERMISSION FOR MY CHILD TO BE ADMINISTERED THE FOLLOWING BY SCHOOL HEALTH PERSONNEL (Approved by School Doctor) **(Please Check YES or NO)**

IBUPROFEN (ADVIL) \_\_\_\_ YES \_\_\_\_ NO

ACETAMINOPHEN (TYLENOL) \_\_\_\_ YES \_\_\_\_ NO

THROAT SPRAY \_\_\_\_ YES \_\_\_\_ NO

COLA SYRUP (GI Upset) \_\_\_\_ YES \_\_\_\_ NO

PEPTO BISMOL \_\_\_\_ YES \_\_\_\_ NO

TUMS \_\_\_\_ YES \_\_\_\_ NO

BENADRYL \_\_\_\_ YES \_\_\_\_ NO

LOZENGES \_\_\_\_ YES \_\_\_\_ NO

NEOSPORIN \_\_\_\_ YES \_\_\_\_ NO

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Please turn over for Page 2



★ **PLEASE BE SURE TO SIGN AND RETURN TO THE SCHOOL NURSE**

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**STUDENT NAME:** \_\_\_\_\_ **GRADE** \_\_\_\_\_

**MEDICAL HISTORY**

**ALLERGIES** \_\_\_\_\_ ☐ YES ☐ NO    **TYPE** \_\_\_\_\_    **EPI PEN** ☐ YES ☐ NO  
**ASTHMA** \_\_\_\_\_ ☐ YES ☐ NO    **INHALER** \_\_\_\_\_ ☐ YES ☐ NO \_\_\_\_\_ N/A  
**SEIZURE DISORDER** \_\_\_\_\_ ☐ YES ☐ NO

Describe: \_\_\_\_\_

**PRESCRIPTION MEDICATIONS TAKEN AT HOME:** \_\_\_\_\_

**DIABETES** \_\_\_\_\_ ☐ YES ☐ NO    \_\_\_\_\_ TYPE I \_\_\_\_\_ TYPE II

Method of Insulin Delivery: \_\_\_\_\_

**CARDIAC CONDITION** \_\_\_\_\_ ☐ YES ☐ NO

Describe: \_\_\_\_\_

**ANNUAL HEALTH UPDATE:**

Serious Illness, Injury, Hospitalization or Operation during the past year? \_\_\_\_\_ ☐ YES ☐ NO

Describe: \_\_\_\_\_

Does your Child have a Hearing and/or Vision Disorder? \_\_\_\_\_ ☐ YES ☐ NO

Describe: \_\_\_\_\_

**IMMUNIZATION UPDATE:**

If your child received any immunizations during the past year, please attach the physician documentation to this form.

I have reviewed this form and certify that all information is complete and accurate. If this information changes during the school year, I will contact the School Nurse with updates.



\_\_\_\_\_  
PARENT/ GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

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