Mt. Lebanon School District

#415
(rev. 1-20)

New Student Health Packet

Dear Parent(s)/Guardian:

Welcome to our school district. We are pleased that you will be joining our school community and hope that your family finds this to be a healthy and supportive learning environment. Please take a moment to read the following information about the nursing services provided at school. If your child has special health care needs, requires medication or health treatments during the school day, or has a chronic health condition, please contact your child's certified school nurse so that we can prepare for his/her entry into school.

EMERGENCY INFORMATION: Parents/Guardians are required to complete the **Emergency Medical Contact/Release Information** page on the parent/guardian Dashboard account for their child. This will need to be done when your child's registration is complete and your child has started school in the Mt.Lebanon School District. This will ensure that we have most current contact information. Please follow these tips:

1. You must go into the parent/guardian Dashboard account, not the account belonging to your child
2. Emergency Medical Contact/Release Information is located under the "account preferences" tab.
3. **Please include parents/guardian (in priority order) as part of your 4 (four) contact options if you wish to be contacted – If you do not – you will not be contacted.**
4. Please enter this information for each student. You may utilize the "copy" form: feature to expedite the process
5. Students with more than one parent/guardian account or families who do not have computer access will need to contact their child's school secretary to request a hard copy of the Emergency Medical Contact/Release Information sheet. The Parent/Guardian will then need to complete the form and return it to their child's building. The building staff will then transfer the information electronically.

IMMUNIZATIONS: All students are required to be in compliance with Pennsylvania and Allegheny County Health Department's immunization regulations for school attendance. Please see the attached form (**408-D**) for specific immunization regulations. To comply with these regulations, a copy of your child's immunization record must be submitted, reviewed and approved by the certified school nurse **before** your child can attend school. (Please see attached).

KINDERGARTEN: All students entering Kindergarten in Allegheny County will be required to have had **LEAD** testing completed prior to the first day of school. Parents/guardians will need to submit written proof, signed by their child's health care provider of such testing, to their child's certified school nurse.

HEALTH HISTORY: Please complete both sides of the attached health history form (**415-A**) and return to your child's nurse's office. This information is kept confidential and shared with appropriate school and medical personnel as deemed medically necessary.

HEALTH CARE TREATMENTS: Emergency care is available in the nurse's office for any illness or injury that is sustained during school hours. The nurse cannot address injuries that occur at home. By law, a nurse is not permitted to make a diagnosis or prescribe treatment.

Children with an elevated temperature (100 or above), vomiting or diarrhea will need to stay home until symptom free for **24 hours without the use of fever reducing medication. Also, if started on antibiotics – will need to be on them for a full 24 hours prior to returning to school.**

The School District adheres to Allegheny County Health Department Guidelines for readmission following a student's communicable disease diagnosis. We are not equipped to provide advanced emergency care. Children needing urgent medical attention will be transported to an emergency care facility by an Ambulance Service. Please notify the nursing office if your child has any health concerns that could result in the need for emergency services, or that need to be communicated to emergency personnel.

HEALTH INSURANCE: If your child does not have health insurance, free or low cost coverage is available through Pennsylvania Children's Health Insurance Program (CHIP). CHIP is administered by the Pennsylvania Insurance Department and the coverage is for quality medical services through private health insurance companies. For more information, please visit www.chipcoverpakiksa.com or call 1-800-986-KIDS.
Applications are also available in your child's school health office.

HEALTH SCREENINGS: The certified school nurse completes health screenings annually. The schedule is as follows:

- Vision, height & weight, BMI percentile in Grades K-12
- Hearing in grades K thru 3rd grade, grade 7 & grade 11, as well as at parent and teacher requests.
- Scoliosis Screening in grades 6 & 7

Referral forms are mailed home for students who do not pass a school screening and require a more thorough examination by his/her private health care provider.

MEDICATIONS: If a licensed health care provider deems it medically necessary for a student to take medication, either prescription or nonprescription during the school day, the Authorization for Medication Form (**#440**) signed by the parent/guardian and completed by the licensed healthcare provider, must be returned to the nurse's office with the medication in a pharmacy labeled container, or an unopened over the counter bottle, dated July1st of the current school year or after. **A separate form is required for each medication. A new, completed form by both the physician and parent is required for each medication change, dose change and for each new academic school year, dated July 1st or after.**

Emergency medications (Epinephrine auto injector, rescue inhalers and diabetic supplies) are the only medications that may be self carried and self administered by students and only after completion of the Authorization for Medication Form #440; Self Carry Form #440F and signed off by the certified school nurse.

PHYSICAL EXAMINATIONS: Pennsylvania Department of Health requires all students in K, 6, 11 and any NEW students with incomplete health records to have a physical examination dated no earlier than September 1 of the previous school year.

DENTAL EXAMINATIONS: **Pennsylvania Department of Health requires all students in K, 3, 7 and NEW students with incomplete health records to have a dental examination dated no earlier than September 1 of the previous school year.**

The school doctor & dentist are available to perform the physical examination or dental examination in school on a limited basis throughout the school year. These school exams are at no cost to you. You may also choose to have your private health care practitioner complete these examinations at your expense.

If you have any questions concerning the preceding topics or other areas pertaining to health services, please contact your child's nurse.

Thank you
The Health Services Department

Mt. Lebanon School District#

415-A
(rev. 1/2020)

HEALTH HISTORY

Student's Name ____________________________________Grade _______ Date of Birth __________

Street Address ____

City ______________________________ Zip _________ Cell/Primary Phone _____________________

Siblings Name	Birth Date	School	Grade

Name and address of school last attended:

Name of School:

Address of School:

Physician: ____ Phone Number __________________

Dentist: ____ Phone Number __________________

Medication: (please list all medications taken):

At Home: ____

At School: ____

*(If required at school, complete form **#440-Authorization for Medicine**)*

OVER

STUDENT NAME: ______________________________ **GRADE** __________

TO BE COMPLETED BY PARENT/GUARDIAN
Please check ✓ ALL that applies to your child

Anxiety		*Developmental Delay*		*Nosebleeds*	
Arthritis		*Diabetes Type 1*		*Orthopedic Condition*	
Asthma		*Diabetes Type 2*		*Rheumatic Disease*	
Attention Deficit Disorder		*Dietary Restrictions*		*Sickle Cell*	
Autoimmune Disorder		*Epilepsy/Seizure Disorder*		*Speech Difficulty*	
Bladder/Bowel Control		*Gastrointestinal Condition*		*Spina Bifida*	
Bleeding Disorder		*Hearing Deficit – right / left*		*TB Exposure*	
Blood Pressure Issues – high or low		*Immunocompromised*		*Thyroid Condition – Specify*	
Cancer		*Inflammatory Bowel Disease*		*Tourette's Syndrome*	
Cardiovascular Condition – Specify		*Kidney Condition*		*Vision: Eye Surgery – Specify*	
Cerebral Palsy		*Mental Health Diagnosis*		*Severe Vision Loss – right / left*	
Chicken Pox (date)		*Migraines*			
Color Vision Deficiency		*Neurological Disorder*			
Dental Condition					

Explain Above Check Marks: ______________________________

Allergies/Reaction: ______________________________

Previous Surgeries/Dates: ______________________________

Other: ______________________________

I understand and agree that any and all of this information may be shared with appropriate school personnel.

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Signature of Certified School Nurse Date

Mt. Lebanon School District

IMMUNIZATION REQUIREMENTS

408-D (Rev.1/2020)

Pennsylvania and Allegheny County Health department (ACHD) Immunization Requirements per 28 PA Code Chapter 23, Subchapter C, require that all children show proof of immunization **before** they may attend any public, private, charter or home school in the Commonwealth. **Your child will not be permitted to attend school until you have submitted documentation of the required immunizations and they have been received and approved by the Certified School Nurse.**

Students who are entering school are required to have the following properly spaced vaccines:

4 *doses of tetanus, diphtheria and acellular pertussis*
(1 dose on or after the 4th birthday); 3 doses, if series ***started after*** *7 years of age*

- *Usually given as DTP or DTaP or DT or TD -* ***NOT*** *Tdap.*

4 *doses of polio*
(4th dose on or after 4th birthday), or 3 doses if 3rd dose ***started on or after*** *the 4th birthday with proper spacing.*
2 *doses of measles, mumps, rubella (usually given as MMR)*
3 *doses of hepatitis B (properly spaced)*
2 *doses of varicella (chickenpox) vaccine*

- *or written statement from parent or health care professional indicating month/year of disease*
- *or proof of immunity by blood test - giving specific titer*

Kindergarten: Lead testing

Students who are in Grades 7-11 are required to have the following vaccines in addition to the above vaccines:
1 dose of tetanus/diphtheria/pertussis (**Tdap**) (**required at 11-12 years of age**)
1 dose of meningococcal conjugate (MCV4 #1)

Students who are entering **Grade 12** are required to have the following vaccine in addition to the above vaccines:
2nd dose of meningococcal conjugate (MCV4 #2)

EXEMPTIONS

MEDICAL Exemption: If the physical condition of your child is such that immunization would endanger life or health, a medical exemption must be submitted. Only licensed medical doctors and doctor of osteopathy and designated Health Department personnel may waive immunization requirements. ***Chiropractors' certification for medical exemptions are not acceptable by law***. If a medical exemption is for a specific antigen(s) this should be indicated in the statement of exemption. All other immunizations will still be required. These statements of exemption must be written by the appropriate medical personnel and submitted to the Certified School Nurse **prior to your child entering school.**

RELIGIOUS Exemption: This includes a strong or ethical conviction similar to a religious belief. The Certified School Nurse must be notified by the parent in writing of the reasons for this exemption **prior to your child entering school.**

If a child is exempt from immunizations and a vaccine preventable disease outbreak occurs, he/she may be excluded from school per the direction from Allegheny County Health Department.

IMMUNIZATIONS

Allegheny County Health Department immunization clinic offers routine recommended vaccines for children up to the age of 18. Immunizations are FREE of charge for those who qualify. Certain insurances are also accepted at the Allegheny County Health immunization clinic.

Children can receive free vaccines at the Allegheny County Health Department clinic if:

- They are on Medicaid
- They have NO health insurance
- Their health insurance does not cover the cost of vaccines
- They are American Indian or Alaskan native

Immunizations are available without an Appointment. Please call the clinic for open dates & times

Allegheny County Health Department **NEW DOWNTOWN LOCATION:**

Hartley Rose Building(near intersection of 1st Avenue & Cherry Way)

425 First Avenue
4th Floor
Pittsburgh, A 15219
Phone: (412) 578- 8062

Public Transportation access via the Port Authority of Allegheny County:

BUS- 42 Bower Hill Rd., exit BLVD of the Allies & Smithfield Street
Subway (**T stations**) - Red & Blue lines **EXIT** 1st Avenue Station

All others should seek immunization services through their Primary Care Physicians (PCP) office.

Mt. Lebanon School District#

Authorization for Medication

#440 (4/2019;10/19/)

Dear Parent/Guardian:

For safety reasons, the administration of student medicines, either prescription or non-prescription, during school hours is strongly discouraged.

If a physician deems it necessary for your child to take medications, either prescription or nonprescription during the school day, the **AUTHORIZATION FOR MEDICATION FORM** (reverse side) must be completed by **both** a parent/guardian and physician and returned to your child's health office prior to any medication being administered.

The following summarizes the procedure:

- *Physician orders **MUST** be completed and dated July 1st or after for the upcoming school year.*
- *Prescription medication must be in the current and appropriate labeled pharmacy container. The order and the pharmacy bottle must match.*
- *Over the counter medication (nonprescription) must be in the original, unopened container and the type of non-prescription medication must match the physician's orders.*
- *A new form completed by **both** the physician and parent/guardian is required for **each** medication**,** medication change, dose change and for **each** new school year, dated July 1st or after for the upcoming school year.*
- *It is the responsibility of your child to report to the health office for his/her medication.*
- *Emergency medications (Epinephrine Auto injector; Rescue inhaler and/or Diabetic Supplies)may be self carried and self administered by students after completion of:*

  Authorization for Medication Form (#440)
  Self-Carry Form (#440 F)

Please remember that your child may not receive his/her medication if these procedures are not followed.

Please feel free to contact your child's certified nurse if you have any questions or concerns regarding this matter.

Thank you for your cooperation.

Health Service Department

Mt. LEBANON SCHOOL DISTRICT HEALTH SERVICES

Authorization for Medication, prescription and non-prescription
to be given during school hours

9/19

Student's Name:______________________ ID# _________School_____________________

Date of Birth__________________ Sex_________________ Grade/Homeroom____________

Physician's Name__________________________ Office Phone Number_________________

TO BE COMPLETED BY LICENSED PRESCRIBER:

MEDICATION	
DOSAGE	
TIME OF ADMINISTRATION; daily or PRN (how often)	
LENGTH OF ADMINISTRATION (i.e. the school year or a shorter time)	
REASON FOR MEDICATION	
ADMINISTRATION INSTRUCTIONS	
SIDE EFFECTS	
SELF-ADMINISTRATION/SELF CARRY (This student is authorized to self-carry his/her Rescue Inhaler; Auto Injecting Epinephrine and/or Diabetic Supplies and medicate himself/herself.	**YES___ PHYSICIAN'S INITIALS_____** **NO___ PHYSICIAN'S INITIALS_____**
SIGNATURE OF LICENSED PRESCRIBER	
DATE	

TO BE COMPLETED BY PARENT/GUARDIAN:

In consideration of Mt. Lebanon School District granting our request to dispense certain medication to our child and/or allow self-administration of medication, the undersigned parents/guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless Mt. Lebanon School District and its School Board, Administrators, Teachers, Secretaries, Nurses and Employees from and against any and all claims, damages, actions or causes of action resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of medication listed above to our said child. **I understand and agree the medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by district personnel. I understand and agree that emergency medication may be administered by District employees who are not nurses.**

Parent/Guardian signature____________________________________ Date_______________

Home Phone #____________________________Work #_______________Cell #_______________

H514.027(8/2011-under review)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL ______________________ DATE ______________ 20 ___

NAME OF CHILD			AGE	SEX	GRADE	SECTION /ROOM
Last	First	Middle		☐ M ☐ F		

ADDRESS

No. and Street | City or Post Office | Borough/Township | County | State | Zip

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT								LEFT								
UPPER	1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 1	13 J	14	15	16	UPPER
LOWER	32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	LOWER
UPPER																	UPPER
LOWER																	LOWER

Is the Child Under Treatment? YES ☐ NO ☐

Treatment Completed? YES ☐ NO ☐

Date of Dental Exam

Signature of Dental Examiner

Print name of Dental Examiner

Address

Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before student's exam. Take completed form to appointment.

Student's name ______________________________ Today's date__________________

Date of birth __________________ Age at time of exam __________ Gender: ☐ Male ☐ Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

____

____

Does the student have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: *Has the student…*	YES	NO
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_______________		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: *Has the student…*	**YES**	**NO**
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: *Has the student...*	**YES**	**NO**
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:__________		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: *Has the student...*	**YES**	**NO**
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: *Has the student…*	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: *Has the student…*	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. **FEMALES ONLY:** Had a menstrual period? ☐ Yes ☐ No If yes: At what age was her first menstrual period? ______ How many periods has she had in the last 12 months? ______ Date of last period: ___________		
DENTAL:	**YES**	**NO**
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: ______________________ Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: *Has the student…*	**YES**	**NO**
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	**YES**	**NO**
42. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_______________________		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_______________		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	**YES**	**NO**
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student_______________________________
Date_______________

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

 STUDENT NAME:

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐

Physical exam for grade: ☐ K/1 ☐ 6 ☐ 11 ☐ Other	CHECK ONE: L	*ABNORMAL	DEFER	*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( ) %				
Pulse: ( )				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected ☐				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(**Additional space on page 4)**

Parent/guardian present during exam: Yes ☐ **No**☐

Physical exam performed at: Personal Health Care Provider's Office ☐ **School** ☐ **Date of exam______________20______**

Print name of examiner ____

Print examiner's office address______________________________ **Phone**________________

Signature of examiner______________________________ **MD** ☐ **DO** ☐ **PAC** ☐ **CRNP** ☐

STUDENT NAME:

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from student's record – OR – insert information below.***

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

Medical ☐ Date Issued:___________ Reason: ____ Date Rescinded:___________

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:___________				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5

Other Vaccines: (Type and Date)

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)

STUDENT NAME:

#

Mt. Lebanon School District

Electronic Emergency Medical Contact/Release Information Request Update

Dear Parents/Guardians:

Parents/Guardians are required to complete an Emergency Medical Contact/Release Information sheet on their children each year. Please check and update your child's emergency Medical Contact/Release information page on Dashboard, if not already competed. **A review/revision is required every school year as well as anytime a change is necessary.** Each time a review/revision has been made, please click "**SUBMIT**" at the bottom of the screen and save the review/revision.

The Emergency Medical Contact/release information page will be used in the event that your child is ill, injured or there is an emergency. **The Emergency Medical Contact/Release information is requested to ensure the safety and security needs of your children. It is important that the information be as accurate and up to date as possible.**

Please not the following tips:

1. You must go in under the parent/guardian's dashboard account, **NOT** the student's.
2. Emergency Medical Contact/Release information is located under "account preferences tab.
3. Please include parents/guardians (in priority order) as part of your four contact options in you wish to be contacted.
4. Please enter this information for each student—you may utilize the "copy from" feature to expedite the process.
5. **If you have completed this information in a previous year, please review it every school year and event if there are not changes, click the "SUBMIT" at the bottom of the screen. This will complete the process and the information will be saved.**
6. Students with more than one parent account or those who do not have access to a computer will need to complete a hard copy of the Emergency Medical Contact Release Information Sheet. Please contact your child's health office or school secretary for a copy of this.
7. If the Emergency Medical Contact/Release Information Sheet is not competed, there will be a deficiency that shows up on your child's and parent/guardian Dashboard account under the balance icon. This will be cleared once the Emergency Contact/Release Information Sheet is completed and updated. No money is due for this.
8. Please contact your child's health office for any issues, concerns or if you will need a hard copy Emergency Medical Contact/Release Information Sheet.

Thank you for your assistance in completing this vital part of your child's health record.

Health Services Department

"Mt. Lebanon is an equal opportunity school district."