LAMPETER-STRASBURG SCHOOL DISTRICT
Health Profile and Consent

Student Name _____Birth Date _____

PARENT / GUARDIAN / EMERGENCY CONTACT
Please indicate if guardians below are other than a parent

Name:	Relationship:	Phone Number:	Email:
Name:	Relationship:	Phone Number:	Email:
Alternate contact, if unable to reach a parent or guardian regarding a medical emergency:			
Name:	Relationship	Phone Number:	

Medical Care

If **EMERGENCY** treatment is required **FOR ANY REASON** and a parent cannot be reached, may the school authorities use their judgement in sending the child to the hospital or doctor most accessible? Yes _____ No _____

Name of Physician _____ Phone _____

Name of Dentist _____ Phone _____

Preferred Hospital _____

Please complete the following as School Health Services are required to report medical information to the Pennsylvania Department of Health in order to obtain appropriate reimbursement for the health care of students in school.

Allergies

Seasonal Allergies: Yes _____ No _____ If Yes, describe symptoms _____

Life threatening/Anaphylactic allergies (food, insect bites, drug allergy): Yes _____ No _____
If YES, please list the life threatening allergies: _____

Does your child carry an Epinephrine Pen? Yes* _____ No _____
*** Complete Medication Permission form and have your health care provider complete an Allergy Action Plan.**

Asthma

Does your student have any Asthma Diagnosis? Yes _____ No _____
If Yes, does your student use an inhaler? Yes _____ No _____

Will your student have an inhaler at school? Yes* _____ No _____
*** Complete Medication Permission form and have your health care provider complete an Asthma Action Plan.**

Seizure Disorder

Seizure disorder: Yes _____ No _____ If YES, does your child require emergency medication? Yes* _____ No _____

Type of seizure _____ Date of last seizure _____
*** Complete Medication Permission form and have your health care provider complete a Seizure Action Plan.**

***Complete other side**

Other Health Concerns / Medications

Check all that apply:

☐ Arthritis	☐ Headaches	☐ Anemia
☐ ADD/ADHD	☐ Bleeding Disorders	☐ Cystic Fibrosis
☐ Heart Disease/High Blood Pressure	☐ Connective Tissue Disorder	☐ Stomach Disorders/GERD
☐ Diabetes/Endocrine Disorders	☐ Weight or Eating Disorder	☐ Immunodeficiency
☐ Kidney Disorders	☐ Hearing Problems	☐ Orthopedic Disorder
☐ Neurologic Disorders	☐ Cancer	☐ Vision/Color Deficit
☐ Sickle Cell Disease	☐ Psychiatric Disorders/Anxiety	☐ Other:_____

Hospitalization/Surgeries and additional comments:_____

Changes in the home may cause stress and anxiety. Are there any recent changes of which we should be aware? (separation, divorce, illness, death, etc.): _____

Medications: List **ALL** medications your child takes on a regular basis, including dose and time of day.

_____

_____

Over The Counter (OTC) Medication Administration
Consent for Secondary Students (6-12)

I give my permission for the School Nurse or Health Room Assistant (LPN/RN) to give my child the following medications according to standing orders by the school physician.

Medication/Solutions	Yes	No	Medication/Solutions	Yes	No
Ibuprofen			Acetaminophen		
Throat lozenges/cough drops			Tums (Antacid)		
Zyrtec (Severe allergy or anaphylactic reasons)			Hydrocortisone Cream		
Benadryl (For anaphylactic reasons only)			Caladryl Lotion		
Generic Oral Antiseptic			Antibiotic Cream		
Orajel/Anbesol			Aloe Vera		
Saline Eye Wash			Sunscreen		
Contact Lens Solution					

Comments: _____

Parent/Guardian Signature for OTC Medicine_____ **Date** _____

Consent to Disclose Information to the School Nurse

_____ I consent to the release of information for immunizations, physicals, and dentals from my local healthcare providers.

_____ I consent to the release of health information, to my school nurse, from my child's primary care provider, for the purpose of creating a health plan, if needed during the school year (i.e. allergies, asthma, seizure disorder).

Parent Signature _____ **Date** _____

Please contact the Nurse with any changes or updates to this information throughout the school year:

Martin Meylin Middle School Nurse
Pamela Fliegel (Grades 6-8)
717-464-3311 ext. 3012 / 717-509-0289 (fax)
pamela_fliegel@l-spioneers.org

Lampeter-Strasburg High School Nurse
Jennifer Rimert (Grades 9-12)
717-464-3311 ext. 2012 / 717-509-0485 (fax)
jennifer_rimert@l-spioneers.org

Access to the above information is restricted to those individuals who have a legitimate educational interest.