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* ________

*If no, indicate the preferred hospital: ____

Medication Administration

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:

Acetaminophen (generic Tylenol) Yes_____ No_____

Ibuprofen (generic Advil/Motrin) Yes_____ No______

Hydrocortisone Cream Yes_____ No______

Antibiotic Ointment Yes_____ No______

Saline Eye Wash Yes_____ No______

Sunscreen Yes_____ No______

Chewable Antacid (Generic Tums) Yes _____ No _____

Throat Lozenges/Cough Drops Yes _____ No _____

Caladryl Yes_____ No______

Orajel/Anbesol Yes_____ No______

Generic Oral Antiseptic Yes_____ No______

Aloe Vera Yes_____ No______

Zyrtec (Severe seasonal/anaphylactic reaction) Yes_____ No_____

Comments: ____

Parent/Guardian Signature: ______________________________ **Date:** ____________________

REQUIRED PHYSICAL AND DENTAL EXAMINATION FOR ENTRY INTO SCHOOL

The PA School Health Law requires children upon original entry to school and in the <u>sixth</u> and <u>eleventh</u> grades to have a complete physical exam.

* **<u>Please check one of the following:</u>**

______ I have already provided this information to the school nurse.

______ I wish to have my family doctor examine my child at my own expense.

______ I wish to have the school doctor examine my child.

The PA School Health Law requires children upon original entry to school and in the <u>third</u> and <u>seventh</u> grades to have a dental exam.

* **<u>Please check one of the following</u>:**

______ I have already provided this information to the school nurse.

______ I wish to have my family dentist examine my child at my own expense.

______ I wish to have the school dentist examine my child.

Students entering <u>twelfth</u> grade must have a second dose of the Meningococcal vaccine (MCV4) before the first day of school or risk exclusion.

_____ 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 High School Nurse with any changes or updates to this information throughout the school year at 717-464-3311, Ext. 2012, or sarah_stuart@L-Spioneers.org.

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