

**FLEETWOOD AREA SCHOOL DISTRICT**

**801 North Richmond Street**

**Fleetwood, PA 19522**

Student name \_\_\_\_\_ grade \_\_\_\_\_ homeroom \_\_\_\_\_  
Parent/Guardian \_\_\_\_\_ phone(s) \_\_\_\_\_  
2nd Emergency Contact \_\_\_\_\_ phone(s) \_\_\_\_\_  
3rd Emergency Contact \_\_\_\_\_ phone(s) \_\_\_\_\_

**1. MEDICAL AND HEALTH INFORMATION UPDATE**

Please check any conditions listed below that may apply to your child and provide a brief explanation if needed.

\_\_\_\_\_ My child **does not** have any medical/health conditions.  
\_\_\_\_\_ My child **does** have a health condition. *If your child had a problem in the past but no longer does, please update by writing NLA—no longer applies—in that space. Thank you.*

- \_\_\_\_\_ ADHD \_\_\_\_\_
- \_\_\_\_\_ Asthma \_\_\_\_\_
- \_\_\_\_\_ Bee sting allergy \_\_\_\_\_
- \_\_\_\_\_ Cardiac condition \_\_\_\_\_
- \_\_\_\_\_ Diabetes \_\_\_\_\_
- \_\_\_\_\_ Drug allergy \_\_\_\_\_
- \_\_\_\_\_ Food Allergy \_\_\_\_\_
- \_\_\_\_\_ Fracture within past year \_\_\_\_\_
- \_\_\_\_\_ Headaches/Migraines \_\_\_\_\_
- \_\_\_\_\_ Hearing or vision impairment \_\_\_\_\_
- \_\_\_\_\_ Hypertension \_\_\_\_\_
- \_\_\_\_\_ Illness or surgery within past year \_\_\_\_\_
- \_\_\_\_\_ Limited physical activity due to \_\_\_\_\_
- \_\_\_\_\_ Seasonal-environmental allergies \_\_\_\_\_
- \_\_\_\_\_ Seizure disorder \_\_\_\_\_
- \_\_\_\_\_ Other chronic or recurrent condition \_\_\_\_\_

**2. PRESCRIPTION MEDICATIONS TAKEN BY YOUR CHILD (AT HOME OR SCHOOL)**

Med _____	dose _____	time given _____	reason _____
Med _____	dose _____	time given _____	reason _____
Med _____	dose _____	time given _____	reason _____
Med _____	dose _____	time given _____	reason _____
Med _____	dose _____	time given _____	reason _____

**3. OVER-THE-COUNTER MEDICATIONS TO BE ADMINISTERED IF NEEDED AT SCHOOL**

Please circle the ones that your child may take.

**Tylenol    Ibuprofen    Benadryl    Maalox    Emetrol(for nausea)    Midol**  
**Robitussin    Sudafed/Dimetapp    Imodium**

If your child needs to take a prescription medication at school, please complete the medication form found on the FASD website and send to school with the medication. If you have questions, wish to update the above information, or object to the sharing of pertinent health information with teachers for your child's safety/comfort, contact your child's nurse.

Parent signature \_\_\_\_\_ date \_\_\_\_\_