GRADE _____

STEELTON-HIGHSPIRE SCHOOL DISTRICT
EMERGENCY AND MEDICATION INFORMATION

Pupil's Name _____ D.O.B. _____
Father's Name _____ Mother's Name _____
Pupil's Address _____ Phone _____

List parent(s) or guardian child lives with:
Name: _____ Relationship to child _____ Home Phone _____
Work Phone _____
Cell Phone _____
Name: _____ Relationship to child _____ Home Phone _____
Work Phone _____
Cell Phone _____

Parent/guardian email _____

In case of illness, emergency, or accident & parent/guardian **cannot** be contacted, the following adults are authorized to act on behalf of the parent/guardian.
1. _____ Phone _____ Relationship _____
2. _____ Phone _____ Relationship _____
Physician's Name _____ Physician's Phone _____
Dentist's Name _____ Dentist's Phone _____
Hospital Preference _____ Insurance Carrier _____

HEALTH INFORMATION-*PLEASE COMPLETE FRONT AND BACK OF FORM*

The following information is considered confidential and is for use by the school nurse and other school personnel who will be in contact with and responsible for your child during the school day. If you prefer talking to the certified school nurse regarding any of the following statements, please contact her directly.

1. CHECK ANY OF THESE CONDITIONS WHICH APPLY TO YOUR CHILD:

____Cancer	____Kidney/Bladder Disease	____Vision Problems	___ADD/ADHD
____Diabetes	____Seizures/Epilepsy	____Hearing Problems	___Arthritis
____Heart Condition	____Orthopedic/ Bone	____Social/Emotional/Behavioral Concerns	
____Autism	____Bowel Concerns	____In Counseling	

____Allergy* to _____ Epipen needed during school/school related activities _____
____Asthma*- Inhaler needed during school/school related activities _____

***For students that may require an inhaler and/or an Epipen, please contact your school nurse for the appropriate forms. These order forms must be completed annually by a parent/guardian and your healthcare provider.**

2. Child takes Medication Daily at _____ Home____ School
Medication is: _____ Dosage/Frequency _____
For: _____

3. Child has a physical condition which limits participation in:
Classroom activities* _____ Gym class* _____ School sports * _____
***If yes, please provide recommendations from your doctor in writing-required annually**

4. Child requires a special diet Yes* _____ No _____
Specify _____
***If yes, please provide recommendations from your doctor in writing-required annually**

5. Please list any additional information, not included above, that you feel that we should know about your child's physical /mental/emotional health which may affect school performance or require special consideration – example: serious injury/illness, family changes, death of a loved one. _____
_____

MEDICATION IN SCHOOL

According to the PA State Health Code, a written order from your child's healthcare provider is required annually for the school nurse to administer any prescription medication or non-prescription medication not covered under the Standing Order Policy. Standing Orders from the school physician include Emergency Medication (epinephrine)-this applies to all students; and Non-Prescription Medication (see below). In compliance with the Standing Order Policy for the Steelton-Highspire School District, the school nurse may administer the following non-prescription medications to students with yearly **written parental authorization**.

I give permission for the school nurse to give the following medication to my child if needed-**please check all that apply:**

ALL GRADES:

( ) Acetaminophen/Tylenol ( ) Ibuprofen/Advil ( ) Benadryl/Generic Equivalent

GRADES 7-12 ONLY

( ) Antacid/Antigas ( ) Pepto-Bismol/Generic Equivalent

( ) I **do not want** my son/daughter to receive any over the counter medication during school.

NOTE: This authorization is valid for the CURRENT SCHOOL YEAR ONLY.

**In the event of an emergency, when a parent/guardian/authorized individual is unavailable or unable to be reached, I authorize school personnel to make arrangements for my child to receive medical/hospital care, including necessary transportation, in accordance with their best judgement.

Parent/Guardian Name (Print):

Parent/Guardian Signature:

Date:

SPECIFIC POLICIES/PROCEDURES RELATING TO THE HEALTH SERVICES DEPARTMENT MAY BE VIEWED ON THE SCHOOL WEBSITE-COPIES MAY BE REQUESTED BY CONTACTING THE SCHOOL NURSE

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