ELIZABETH FORWARD SCHOOL DISTRICT

401 Rock Run Road, Elizabeth, PA 15037-2416 · 412-896-2310 · FAX: 412-751-9483 · www.efsd.net

Mr. Keith Konyk
Superintendent

Every Student Must Have Immunization Records Before Entering School

Name _____ Date of Birth *(mm/dd/yyyy)* _____

Please indicate if your child has any of the following conditions and list any medication(s) he/she is taking at this time.

CONDITION	NO	YES	SPECIFY
Allergies			
Asthma			
Cardiac			
Chickenpox			
If your child had Chickenpox,	*please specify month and year:*		
Diabetes			
Ear Infections			
Epilepsy			
Rheumatic Fever			
Tuberculosis			
TB Contact			
Surgeries			
*Restricted from physical activity			

Does your child have any problems or conditions that you believe the nurse or teacher should know about in order to help him/her? Please be specific:

_____

_____

Current Medications:

_____

Physician's Name: _____ Phone Number: _____

<u>Voluntary Consent of Parents</u>

To better meet your child's safety needs, we will share the health information listed above with staff members. Note that in case of food allergies, it may be necessary to inform parent groups (if they will be hosting a food event). If for some reason you do not want this information shared, please notify your building principal in WRITING!

Signature of Parent/Guardian _____ Date _____

Phone Numbers Home _____ Work _____ Cell _____