Pennridge School District
Students with Life-Threatening Health Conditions

Place Child's
Picture Here

Date: _____

Dear Parent or Guardian:

Please complete this form and return it to the school nurse.

Your child's safety and well being is a priority. We recommend that parents of children who have a life-threatening health condition obtain a medication or treatment plan signed by a licensed health care provider and provide it to the school each year. Please make plans to schedule an appointment with your child's physician or health care provider as soon as possible to obtain a signed medication or treatment plan. Provide a copy of the plan to the school nurse. This information will be shared with appropriate school personnel. **Please attach a wallet sized picture of your child to this completed plan. Contact the school nurse if you have any questions, or if you need a medication/treatment plan form.**

Name of Student _____ School _____

Name of Parent/Guardian _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail address _____

Please complete and return this form for each child who has a serious or life-threatening condition that may put him/her in danger that may require medical services to be performed at school if a medical or treatment plan is not in place.

_____ severe asthma
_____ food allergy: _____
_____ bee sting allergy
_____ diabetes
_____ seizures
_____ other: _____

_____ **I have attached a medication or treatment plan**. **Please include most recent allergy test results**
_____ I will provide a medication or treatment plan by _____ (date)
.
_____ 504-(Section 504 specifically outlines a process for schools to use in determining whether a student has a disability and what services may be needed. If you would like information from the Guidance Counselor, please put a check on this line.

Signature of Parent/Guardian _____ Date_____