

Central Greene Kindergarten Registration

Central Greene School District will be holding Kindergarten Registration by **appointment only** for the 2026-2027 school year. Registration appointments will be from 8:30 – 11:00 and 12:30 – 2:30. Parents are to call the school to select a time on the following days:

Student Last Name A-I - Tuesday, March 24, 2026

Student Last Name J-R – Wednesday, March 25, 2026

Student Last Name S-Z – Thursday, March 26, 2026

In order to speed up the process, registration packets may be completed in advance and brought to the elementary school main office. Central Greene School District will be distributing registration packets at:

1. Waynesburg Central Elementary School main office
2. Available to print from website www.cgisd.org

Central Greene's policy states that a child who is eligible for admission to kindergarten if he/she is not less than five (5) years old on or before September 1st. Any child who will be 6 years of age before the same date may attend first grade. A child who now is attending kindergarten already is registered for first grade and need not register again.

It is important to register your child for kindergarten or first grade even if you are not certain at this point that you will be sending your child to school.

Please bring **proof of birth** (birth certificate, notarized copy of birth certificate, baptismal certificate, copy of baptism if notarized or duly certified and showing date of birth, notarized statement from the parents or another relative indicating the date of birth, or valid passport); **immunization records**; and **proof of residency** (a deed, a lease, current utility bill, property tax bill, vehicle registration or department of transportation identification card).

Immunization records can be faxed to the WCES office at 724-852-1160 or emailed to jbrotherton@cgisd.org or lmccollum@cgisd.org.

The school nurse will check all immunization records and will give guidance on physical problems. If your child has any unusual medical conditions or history, bring the treating physician's name and address. The required immunizations for registration are as follows:

- Four D.T. immunizations (with one being on or after the fourth birthday)
- Four polio (with one being on or after the fourth birthday)
- Two measles, mumps and rubella
- Three hepatitis B
- Two chickenpox vaccine-or documented proof of disease or titer level from your physician.
- To schedule an appointment, call the WCES school office at 724-627-3081.

CENTRAL GREENE SCHOOL DISTRICT REGISTRATION FORM

Entry Date: _____ Entry Code: _____ Student Number: _____

School: _____ Grade Level: _____ Class Assigned to: _____

Bus # AM: _____ PM#: _____ Chorus: _____ Band: _____ Locker #: _____

IEP: Yes ___ No ___ Retained: _____ Registrar's Initials: _____

Previous School: _____

Verification: Birth Certificate: _____ Other: _____ Gender: Male ___ Female ___

Ethnicity: American Indian/Alaskan Native: _____ Asian: _____ Black/African American: _____ White: _____

Native Hawaiian/Other Pacific Islander: _____ Race: Hispanic/Latino ___ Not Hispanic/Latino: _____

Student's Name: _____

First Middle Last

Student's Date of Birth: _____ Birth City & State: _____

Student's Primary Physical Address:

Street Number Street Name City*State*Zip

Mailing Address: (if different from above) _____

Student's Parent/Guardian Information: _____

First Name Last Name

Mother Father Step Father Step Mother Guardian: _____

Address:

Street Number Street Name City*State*Zip

Phone Number: _____ Home/Cell/Work Email: _____

Student's Parent/Guardian Information: _____

First Name Last Name

Mother Father Step Father Step Mother Guardian: _____

Address:

Street Number Street Name City*State*Zip

Phone Number: _____ Home/Cell/Work Email: _____

Is there a Court Order involving this student? Yes ___ No ___ (If **YES**, please provide a copy to the school, otherwise we are unable to abide by its contents.)

Other children living at this address:

Name: _____ DOB _____ Grade _____ School _____

Name: _____ DOB _____ Grade _____ School _____

Name: _____ DOB _____ Grade _____ School _____

1305 ___ 1306 ___ Resident ___ Non-Resident ___ Previous CGSD student ___

HOME LANGUAGE SURVEY

ALL newly registering students regardless of race, nationality, or language origin MUST complete this form. Federal law requires that all Local Education Agencies (LEAs) utilize a non-biased procedure for identifying which students are potential English Learners (ELs) in order to provide appropriate language instruction educational programs and services. Given this responsibility, LEAs have the right to ask for the information contained on this and other forms associated with the identification process.

Student Information (Parents/Guardians should complete this section):

Child's first name: _____

Child's family name: _____

Child's Date of Birth: _____
(Month/Day/Year)

Questions for Parents or Guardians

1. Is a language other than English spoken in the child's home? No Yes (language) _____
2. Does your child communicate in a language other than English? No Yes (language) _____
3. What is the language that your child first learned to speak? _____
4. In which language do you prefer to receive information? _____

Parent/Guardian Signature: _____ Date _____

Interpreter Provided No Yes

CENTRAL GREENE SCHOOL DISTRICT
STUDENT RESIDENCY QUESTIONNAIRE



Dear Parent or Guardian,

Your responses to these questions will help staff determine what residency documents are necessary for enrollment of your child(ren.) Thank you for your cooperation.

1. Student name _____ Birth Date: _____
Person completing form: _____ Relationship to child: _____

2. In what type of setting is the student living now?

Check one box below -

SECTION A	SECTION B
<p><input type="checkbox"/> In an emergency or transitional shelter</p> <p><input type="checkbox"/> Sharing the housing of other persons due to loss of housing, economic hardship, or similar reason</p> <p><input type="checkbox"/> In a motel, hotel, campsites, or cars due to a lack of alternative adequate accommodations</p> <p><input type="checkbox"/> In a car, park, public spaces, abandoned building, substandard housing, bus or train stations, or similar settings</p> <p><input type="checkbox"/> Other places not designed for, or ordinarily used as, a regular sleeping accommodations for human beings</p> <p>CONTINUE to Question 3  if you checked any box in SECTION A</p>	<p><input type="checkbox"/> None of the choices in Section A apply.</p> <p></p> <p>If you checked this section, you do not need to complete the remainder of this form. Submit the form to school personnel now.</p>

3. Contact number for person completing the form: _____
Address where student is now living: _____

4. The student lives with:
Check all that apply

- Parent(s) or legal guardian
- Relative, friend(s), or other adult(s)
- Alone
- Other: _____



5. School student attended last : _____

Address of school: _____

Telephone number of school: _____

Contact person at school (if known): _____

6. Does the student have an IEP or a Chapter 15/504 agreement?

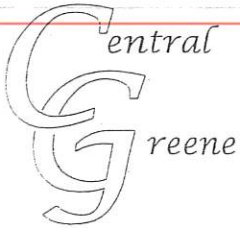
NO

YES. Please explain: _____

Signature of Parent/Legal Guardian:

Date:

—



Excellence is Our Standard

Edith Woods
Director of Special Education
90 Zimmerman Dr
Waynesburg, Pa 15370
(724) 627-3081

CENTRAL GREENE SPEECH-LANGUAGE SCREENING

Name of child: _____ Date: _____
 Parent Name: _____ School: _____
 Address: _____ Home Phone: _____
 City/Zip: _____ Date of Birth: _____ Age: _____
 Teacher: _____ Grade: _____

Dear Parent(s):

Please complete this form as accurately as possible.

When a new student enters into Central Greene School District, they automatically receive a state-mandated speech-language screening. You will be notified of the results via letter or phone conference. If your child's speech and language skills are not age appropriate with your permission, we will conduct a full speech-language evaluation.

- | | Yes | No |
|---|-------|-------|
| 1. Is your child's speech difficult to understand? | _____ | _____ |
| 2. Does your child sound different from other children their age? | _____ | _____ |
| 3. Was your child late in starting to talk? | _____ | _____ |

If so explain _____

		Yes	No
4.	Does your child have difficulty following directions?	_____	_____

If so, explain: _____

		Yes	No
5.	Can your child imitate sounds?	_____	_____
	Can your child imitate words?	_____	_____
	Can your child name pictures/objects?	_____	_____
	Can your child use appropriate sentence structure?	_____	_____
6.	Has your child ever received speech/language services?	_____	_____

If yes please indicate:

Facility: _____ Phone: _____

Address: _____ Therapist's Name: _____

Dates of therapy from _____ to _____

7. Please describe your child's speech/language development along with any comments or concerns you may have regarding your child _____

Examiner's initials	Parent's Signature
---------------------	--------------------

Central Greene School District Hearing Screenings Kindergarten Registration

Please answer the following questions:

Child's name: _____ Birth Date: _____

Parent/Guardian's name: _____ Phone Number: _____

Address: _____

1.) Does your child have a hearing impairment? Yes No

2.) Does your child have a history of ear infections? Yes No
- If yes, how many in one year? _____

3.) Does your child have tubes in his/her ears? Yes No
-If yes, when were the tubes put in? _____

Hearing Specialist use only

250 500 1000 2000 4000 8000

R

L

Pass

Fail



CONSENT FORM
Children's Vision Screening Program

Dear Parent or Guardian:

It is important to check your child's eyes at an early age because a vision problem can be undetectable, and your child may not complain because they don't realize they have a problem.

The Prevention of Blindness Program of the Washington-Greene County Blind Association will be conducting a preschool vision screening at your child's learning center on ____/____/____.

As the undersigned parent/guardian, I hereby grant permission to the Washington-Greene County Blind Association to screen the vision of the child whose name appears below.

Child's Name _____ Birth Date _____ Sex ___M___F

Parent(s) /Guardian's Name _____ Telephone _____

Address _____

Email Address _____

If a professional examination is recommended, I give my consent to permit the Washington-Greene County Blind Association to obtain information from the examining eye specialist regarding my child's eye examination and recommended treatment and to furnish such information, as needed, to the appropriate school/agency. I also understand that follow-up is required and that I may be contacted by the agency for further information.

In addition, I understand that this procedure is a limited vision screening designed only to detect certain symptoms of potential vision problems in children. It is **not** an eye examination and is not intended to take the place of a professional eye examination.

Parent/Guardian Signature: _____ **Date:** _____

Has your child had a professional eye examination by an **ophthalmologist or an optometrist**?

Yes _____ No _____

If yes, Doctor's Name: _____ Date: _____

Please remember, as your child doesn't know how well he/she should be able to see, he/she will probably not complain of problems with vision. Therefore, it is very important to observe behavior patterns which may indicate eye disorders. In this respect, please indicate with an (X) if your child ...

- | | |
|--|--|
| <input type="checkbox"/> Has crossed eyes | <input type="checkbox"/> Rubs his/her eyes a great deal |
| <input type="checkbox"/> Shuts or covers one eye | <input type="checkbox"/> Seem to blink more than usual |
| <input type="checkbox"/> Holds books close to his/her eyes | <input type="checkbox"/> Stumbles easily over small objects |
| <input type="checkbox"/> Becomes irritable when doing close work | <input type="checkbox"/> Squints, frowns when looking at something closely |
| <input type="checkbox"/> Tilts or thrusts head forward to see | <input type="checkbox"/> Has red or watery eyes |
| <input type="checkbox"/> Other observations: _____ | |

Thank you!

Date: _____ **Results:** _____ **Screeener's Initials:** _____

CENTRAL GREENE SCHOOL DISTRICT

Dear Parent or Guardian:

The School Health Law requires medical examinations for children in Grades K or 1st, 6th, 11th and new students from out of state. Also, the School Health Law requires dental examinations for children in Grades K or 1st, 3rd, 7th and new students from out of state. These grades were selected because they represent critical periods of growth and development in a child's life.

The medical examinations can be done by our school physician and dental examinations can be done by our school dental hygienist. Although the Pennsylvania Department of Health recommends that these examinations be done by your family physician or dental office since he/she can best evaluate your child's health and assist you in obtaining necessary treatments and corrections.

Examinations done by family physicians or dentist within one year prior to the student's into the grade in which the exams required and recorded on a form provided by the school are accepted for the required examination year.

PLEASE CHECK YOUR PREFERENCE:

_____ Student to be examined by the **school physician**

Parent/Guardian will be present: **Y** or **N**

_____ Student to be examined by the **school dental hygienist**.

_____ Student to be examined by **family physician** at personal expense of the Parent/Guardian. Please send me the required form.

_____ Student to be examined by **dental hygienist** at personal expense of the Parent/Guardian. Please send me the required form.

**PLEASE COMPLETE AND RETURN THIS FORM TO THE CHILD'S
TEACHER IMMEDIATELY.**

Child's Name: _____

Parent/Guardian Signature: _____ Date: _____

CENTRAL GREENE SCHOOL DISTRICT

RELEASE OF INFORMATION

I, _____, parent/guardian of
_____ hereby give permission to The
Central Greene School District to release information on the above name student to
faculty/staff on a need to know basis concerning any health needs or problems that my
child currently has or may develop in the future. This sharing of information with other
faculty/staff is important to ensure the welfare and safety of your child during school
hours.

Parent/guardian signature: _____

Date: _____

Witness signature: _____

Date: _____

**CENTRAL GREENE SCHOOL DISTRICT
WAYNESBURG, PENNSYLVANIA**

Teacher: _____ Grade: _____ Date: _____

Name: _____ D.O.B. _____ Sex: Male _____ Female _____

Father's Name: _____

Mother's Name: _____ Maiden: _____

Home Address: _____ Telephone: _____

Name whom pupil lives with if other than parent _____

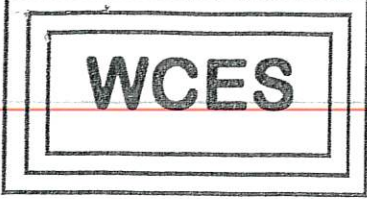
IF YOUR CHILD NEEDS TO TAKE MEDICATION AT SCHOOL FOR ANY REASON-YOU MUST PROVIDE ALL OF THE FOLLOWING:

- A DOCTOR'S SPECIFIC ORDER
- PARENTAL CONSENT
- THE MEDICATION IN THE ORIGINAL CONTAINER FROM THE PHARMACY

Child's Physician: _____ Phone Number: _____

HEALTH HISTORY- PLEASE CIRCLE YES OR NO

- | | | |
|--|-----|----|
| 1. Does your child have a bee sting allergy?
What type of reaction results from this? _____ | Yes | No |
| 2. Has the child had chickenpox?
Date of illness or vaccine: _____ | Yes | No |
| 3. Has the child had any troubles with ears or hearing?
If the child has tubes, when were they inserted? _____ | Yes | No |
| 4. Has the child had any trouble with eyes or seeing?
If the child has glasses, when should they be worn? _____ | Yes | No |
| 5. Does your child have diabetes? | Yes | No |
| 6. Has the child ever had a convulsion (fit or seizure)? | Yes | No |
| 7. Has the child ever had a fainting spell? | Yes | No |
| 8. Has a doctor ever said the child has a heart murmur?
Any restrictions? _____ | Yes | No |
| 9. Has the child ever had an allergy?
To what? (Medications, food, environment) _____ | Yes | No |
| 10. Has the child ever had asthma?
Medications taken? _____ | Yes | No |
| 11. Has the child ever been treated for ADHD, O.D.D. or any behavior disorders?
(please circle from the choices above)
List of medication being taken: _____ | Yes | No |
| 12. Has the child ever has surgery?
If yes, for what reason: _____ | Yes | No |
| 13. List any illnesses, injuries or other conditions not listed above
_____ | | |



Waynesburg Central Elementary School

90 Zimmerman Drive
Waynesburg, Pennsylvania 15370-8281
Phone: 724-627-3081
Fax: 724-852-1160

To: Parents/Guardians
From: School Nurses
Subject: School Medication Procedures

Any prescribed or over the counter medication will be administered at school only by a written order from the doctor stating that it is absolutely necessary that specific medication be given during school hours. **Please make every effort to have any medication given at times other than school hours. (Examples of over the counter medications include Tylenol, Motrin, cough drops, cough syrup, topical creams, etc.)** The school nurse has standing orders for some topical creams such as Neosporin, Cortisone and Benadryl creams. Please check with the nurse regarding your child's need. If these creams are needed, no physician order will be needed. A parent note will be sufficient.

Medication to be given during the school day will require a medication administration form to be filled out and signed by the parent and physician. These forms are available at the nurses' office.

The medication must be brought to the Nurses' office in a container that has a current prescription label from the pharmacy. Please ask your pharmacist to provide you with an extra labeled container for school. If the medication is over the counter, please bring the medication in the original container.

Students are not permitted to carry medication or inhalers except when a physician's order is on file giving them permission to do so.

Parents are responsible for the transportation of medication to and from school. If the parent cannot bring the medication to school, another responsible adult should bring the medication to school.

This is for your child's protection as well as the protection of others. If you have questions, please contact the School Nurse.

I have read and understand the above policy.

Student Name

Teacher

Parent/Guardian Signature

Date



Bureau of Community Health Systems
Division of School Health

**Private or School
PHYSICAL EXAMINATION
OF SCHOOL AGE STUDENT**

PARENT / GUARDIAN / STUDENT:

Complete page one of this form before
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____
Date of birth _____ Age at time of exam _____ Gender: Male Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)

Medicines Pollens Food Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: Has the student...	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: Has the student...	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: Has the student...	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: Has the student...	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: Has the student...	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: Has the student...	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: Has the student...	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
 (Additional space on page 4)

Parent/guardian present during exam: Yes No

Physical exam performed at: Personal Health Care Provider's Office School Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD DO PAC CRNP

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____

NAME OF CHILD			AGE	SEX		GRADE	SECTION/ROOM
Last	First	Middle		<input type="checkbox"/> M	<input type="checkbox"/> F		

ADDRESS _____

No. and Street	City or Post Office	Borough or Township	Country	State	Zip
----------------	---------------------	---------------------	---------	-------	-----

REPORT OF EXAMINATION

TOOTH CHART

	RIGHT									LEFT						
UPPER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
				A	B	C	D	E	F	G	H	I	J			
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			
UPPER																
LOWER																

Is the Child Under Treatment YES NO

Treatment Completed YES NO

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address

LAST NAME	FIRST NAME	MIDDLE NAME	HOMEROOM	GRADE

Please list any health conditions, diseases, allergies, comments or treatments below and make corrections as needed.

Medical Condition	Medication Dosage	Comments

Please bring the doctor's order and the medication to school as soon as possible for any medication that may be needed during the school day. The medication **must be** in the original bottle/package from the pharmacy. **DO NOT SEND MEDICATION WITH YOUR CHILD.**

Student's physician: _____ Phone Number: _____

List any serious illnesses, injuries or surgeries since last school year: _____

By signing below, I understand that the school nurse may share information relevant to my child's health condition with appropriate school personnel as needed to meet my child's health and safety needs. If we are unable to reach the parent/guardian in the event of an injury or illness requiring emergency medical care, the child will be taken to the nearest medical facility.

I also understand that by signing this form, I acknowledge that I am aware of the policies, rules and regulations contained in these documents.

Signature of Parent/Guardian: _____ Date: _____

Parental Permission required for over-the-counter medications.

The following medicine are available through the Health Office and if you check **YES** below, the medicine will be given at manufacturer's directions for age/weight and dose. If your child request Health Office medicine more than 3 times, the child's doctor would then need to complete the school's Medication form, and the parent/guardian would need to provide the medicine in the original medication container. Check the medicine you permit your child to receive.

Tylenol: Yes <input type="checkbox"/> No <input type="checkbox"/>	Ibuprofen: Yes <input type="checkbox"/> No <input type="checkbox"/>	Benadryl: Yes <input type="checkbox"/> No <input type="checkbox"/>
Tums: Yes <input type="checkbox"/> No <input type="checkbox"/>	Cough drops: Yes <input type="checkbox"/> No <input type="checkbox"/>	Midol: Yes <input type="checkbox"/> No <input type="checkbox"/>

I agree to permit the school to administer this medication to my child. In consideration of the school district's agreement to use good faith efforts to properly administer the medication, the district is hereby relieved from liability for any failure to properly administer this medication.

***Parents of elementary students will be notified prior to administration.**

Signature of Parent/Guardian: _____ Date: _____