

2025-2026	District: Brandywine	School: SUMMER ACADEMY/CREDIT RECOVERY			
Student:	ID:	Gender:	Grade:	Date of Birth:	

Student Health History Update for the School Nurse: This information will be shared with staff and administration on a need to know basis, and with emergency medical staff in the case of an emergency, unless you notify us otherwise.

1. Please check if child has had difficulty with any of the following. Please provide dates and additional information in the comments section.

☐ ADHD	☐ Bleeding/Blood disorder	☐ Diabetes	☐ Infections	☐ Speech	☐ Other: _____
☐ Allergies	☐ Bone Problem	☐ Emotional	☐ Kidney	☐ Surgery	
☐ Asthma	☐ Bowel/Bladder	☐ Hearing	☐ Physical Disability	☐ Vision	_____
☐ Behavior	☐ Concussion: _____	☐ Heart	☐ Seizures		

Comments: _____

2. Does your child have allergies to medicine, latex or insect bites? ☐ Yes ☐ No

To What? _____ What Happens? _____

Treatment: _____

3. Does your child have a food allergy documented by a licensed healthcare provider? ☐ Yes ☐ No

To What? _____ What Happens? _____

Treatment: _____

A Food Allergy Action Plan completed by a licensed healthcare provider is required for all students with a food allergy.

4. Will your child require an individualized, allergen-free menu designed by a Brandywine School District Registered Dietitian?

Note: Meals provided from home provide the safest food options at school for food-allergic students.

☐ **No.** I will take full responsibility of providing my child with allergen-free school meals.

☐ **Yes.** I will provide the school nurse with a Food Allergy Action Plan completed by a licensed healthcare provider. Failure to provide physician documentation will result in your student receiving a standard allergy meal.

5. Has your child seen a healthcare provider since school ended in June? ☐ Yes ☐ No

What for? _____

6. Is your child being treated or evaluated for any health conditions? ☐ Yes ☐ No

List condition(s): _____

7. Is your child on any medication or treatment? ☐ Yes ☐ No

Name of medication or treatment: _____

Does your child need medication during school hours? **If yes, please contact the school nurse to make arrangements.** ☐ Yes ☐ No

8. Has your child been prescribed glasses or contact lenses? ☐ Yes ☐ No

Date of last exam: _____ If your child wears glasses or contact lenses, when was the prescription last changed? _____

9. Has your child experienced emotional upsets (recent move, death, separation, divorce) since school ended in June? ☐ Yes ☐ No

Please list: _____

Medical Information:		Last Appointment:	
Family Physician:		Phone:	
Family Dentist:		Phone:	
Medical Insurance:		Type:	
Certificate No:		Group No:	
		Medicaid No:	

I give permission for my child to have the following; as determined by the nurse:

Acetaminophen (Tylenol®) ☐ Yes ☐ No Benadryl ☐ Yes ☐ No Ibuprofen (Advil®) ☐ Yes ☐ No Tums® ☐ Yes ☐ No

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

School Emergency Procedures: Your schools have adopted the following procedures that will normally be followed in caring for your child when he/she becomes sick or injured at school. In extreme emergencies the school may call an ambulance prior to calling parents in order to seek immediate medical care.

In case of emergency and/or need of medical or hospital care:

- | | |
|--|---|
| 1. The school will call the home. If there is no answer, | 5. Based upon the medical judgment of the attending physician, the student may be admitted to a local medical facility. |
| 2. The school will call the parent/guardian 1's, or parent/guardian 2's place of employment. If there is no answer, | 6. The school will continue to call the parents, guardians or physician until one is reached. |
| 3. The school will call the other telephone number(s) listed and the physician. | 7. The information on this form may be shared with emergency medical staff. |
| 4. If none of the above answer, the school will call an ambulance, if necessary, to transport the student to a local medical facility. | |

If I cannot be reached and the school authorities have followed the procedures described, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.

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

*For all purposes herein, an electronic or typed signature shall be deemed the same as an original signature.