

Big Spring School District Health Services
Annual Health Survey
Mt. Rock 776-2425 Newville 776-2435 Oak Flat 776-2445

Parents/Guardians: Please **complete entirely both sides** of this form and the attached permission forms.

STUDENT NAME: _____ **Grade:** _____ **Birthdate:** _____

First Emergency Contact during the day: NAME: _____

BEST NUMBER: _____ **BEST EMAIL ADDRESS:** _____

PHYSICIAN: _____ **DENTIST:** _____

***Please ensure all Aspen contact, emergency information, and telephone numbers are current.**

***Please share emergency health information with your student's bus driver as you feel is necessary.**

Medical History/Medication Administration - Please circle "yes" or "no" and explain the type of care needed:

Yes	No	<i>If I cannot be contacted and my student's temperature is over 101° administer, please give: Tylenol _____ Ibuprofen _____</i>			
Yes	No	Is your student covered by Medical Insurance? Name of Insurance Company: _____			
Yes	No	ADD/ADHD: _____		If medicated, name of medication: _____	
		Is medication given at home? _____		Is medication ordered to be given at school*? _____	
Yes	No	Medication (s)* currently taking and the reason: _____			
Yes	No	Asthma _____	Rescue inhaler*? _____	Nebulizer*? _____	Rest? _____
Yes	No	Bee/insect sting allergy _____	Treatment if needed: _____	Benadryl*? _____	Epi-pen *? _____
Yes	No	Family changes affecting school performance _____		Explain: _____	
Yes	No	Chronic or recurring condition or diagnosis _____		Explain: _____	
Yes	No	Condition limiting activity or Physical Education _____		Explain: _____	
Yes	No	Diabetes _____			
Yes	No	Drug/medication allergy _____		Explain: _____	
Yes	No	Food allergy _____		Explain: _____	
Yes	No	Frequent headaches or migraines _____			
Yes	No	History of concussion _____		Date: _____	
Yes	No	Hearing problem or vision problem _____		Explain: _____	
Yes	No	Heart or cardiac problem _____		Explain: _____	
Yes	No	Lactose intolerance _____			
Yes	No	Seizure disorder/epilepsy _____		Explain: _____ Date of last seizure? _____	
Yes	No	Special dietary needs _____		Explain: _____	
Yes	No	Surgery in the past year _____		Explain: _____	
Yes	No	Any condition requiring ongoing care by physician: _____			

*A physician and parent-signed medication form is required for medications given at school, including inhalers. Prescription medications require a physician order.

Parental Permission

- Permission is given to the nurse or other authority to transport my student home, to the doctor or other area for emergency care and to share this information with staff, bus driver, and contracted physician and dentist as needed.
- Permission is given for the use of other first aid supplies used in the health room including: EpiPen, Benadryl, Benadryl cream, hydrocortisone cream, sting swab, triple antibiotic ointment, eye wash, Calagel/calamine, saline eye drops, coke syrup, hydrogen peroxide, burn gel, sting swab, throat spray, or oral gel. Medical Standing Orders are available for your review and upon request.
- Permission is given to the School Nurse to **conduct state mandated health screening procedures** to assess growth (height and weight), hearing, vision, and scalp/hair for head lice. You will be notified if your student fails the vision and/or hearing screening. If you do not wish for your student to participate in health screenings, please contact the nurse.
- Over the counter medication may be brought to school with a parent note detailing dosage. The medication should be in the original container labeled with the student's name, grade, and teacher's name. Cough drops may also be brought to school for student use **with a parent note**.

Parent Signature _____ **Date:** _____

Kindergarten-yellow 1st grade – blue 2nd grade – green 3rd grade – pink 4th grade – tan 5th grade - grey

*******PLEASE READ AND SIGN THE BACK OF THIS FORM*******

ATTENTION 1st grade and 3rd grade PARENTS

DENTAL EXAMINATION PERMISSION

The Pennsylvania School Health Act requires a dental examination for children in the **1st, 3rd**, and 7th grades. We encourage that this be completed by your family dentist and reported to the school. However, the school dentist can do this exam. The exam consists of the dentist observing at your child's teeth. ***No cleaning or treatment is performed. If treatment and/or cleaning is needed, you will be notified and will need to make a dental appointment.***

If you would like a dental examination done at school this year by our school dentist, please complete and sign the permission section below, indicating your preferences. An examination cannot be performed without the written permission of a parent or guardian.

_____ I give permission for my child, _____, to be examined by the school dentist. (Medical information may be shared with the dentist as needed.)

_____ I **DO NOT GIVE PERMISSION** for my child to be examined by the school dentist. I will schedule an appointment with my child's dentist, Dr. _____.

Parent/Guardian Signature _____ Date _____

ATTENTION KINDERGARTEN AND NEW STUDENT PARENTS

PHYSICAL EXAMINATION PERMISSION

The Pennsylvania School Health Act requires a medical examination for children on original entry (KINDERGARTEN/FIRST GRADE) and transferring from out of state into a Pennsylvania school. These examinations are recommended because these are critical periods in your child's growth and development. We suggest that the exam be done by your family doctor since he or she can best evaluate your child's health and assist you in obtaining necessary treatment. However, if you prefer, the school physician can do this examination at school.

If you would like this exam done at school this year by our school physician, Dr. Darryl Guistwite, please complete and sign the permission section below, indicating your preferences. An examination cannot be performed without the written permission of a parent or guardian.

_____ I give permission for my child, _____, to be examined by the school physician, Dr. Darryl Guistwite. (Medical information may be shared with the physician as needed.)

_____ I **DO NOT GIVE PERMISSION** for my child to be examined by the school physician. I will schedule an appointment with my child's physician, Dr. _____.

Parent/Guardian Signature _____ Date _____

Non-Aerosol Topical Sunscreen Use Parent/Guardian Form

Student Name: _____ Grade: _____

Parents/guardians may choose to supply their child with **non-aerosol topical sunscreen**, if it is approved by the U.S. Food and Drug Administration. Parents/guardians must complete and submit the following information in order for their child to apply sunscreen during school hours, at a school-sponsored activity, or while under the supervision of school personnel.

A school may cancel or restrict the possession, application, or use of a non-aerosol topical sunscreen product by a student if any of the following occurs:

- The student fails to comply with school rules concerning the possession, application, or use of the non-aerosol topical sunscreen product.
- The student shows an unwillingness or inability to safeguard the non-aerosol topical sunscreen product from access by other students.

☐ By checking this box, you confirm that you are the parent/guardian of the student.

☐ By checking this box, you confirm that you understand that the school is not responsible for ensuring that the sunscreen is applied by the student.

☐ By checking this box, you confirm that the student has demonstrated that they are able to self-apply the sunscreen, and you confirm that your student knows the proper safety precautions for the handling and disposing of the non-aerosol topical sunscreen product.

Parent/Guardian Signature: _____ Date: _____