QUAKERTOWN COMMUNITY SENIOR HIGH SCHOOL

Annual Health Update Form

2016-17

Student Name: ____ **Grade:** _____________

1. **Within the past year** has your child experienced a serious illness or injury? **(<u>Circle</u> answer)** Yes No
   If yes, please explain:

2. **Within the past year** has your child required any ongoing treatment or surgery **(<u>Circle</u> answer)** Yes No
   If yes, please explain:

3. Does your child have any of the following? **<u>Circle</u> all that apply:**
   Asthma ADD/ADHD
   Diabetes Heart Murmur
   Seizure Disorder GERD/ GI disorder/IBS
   Seasonal/Environmental allergies: ______________
   List on the reverse side of this form any additional health concerns or conditions that you wish to share.

4. Does your child require any restrictions **- especially in physical education (PE)? (<u>Circle</u> answer)** Yes No
   If yes, explain:

5. Does your child take medication **at home or in school** on a daily or as-needed basis? (Include inhaler if used). **(<u>Circle</u> answer)** Yes No

   If yes, list **medication, dose, and times given:**

6. Has your child had a **<u>SERIOUS ALLERGIC</u>** reaction (requiring **<u>HOSPITALIZATION</u>** or **<u>EMERGENCY ROOM CARE</u>**) to any of the following? (<u>CIRCLE all that apply)</u>

   Food Allergies: List symptoms and history of treatment.
   ____

   Insect Stings: List symptoms and history of treatment.
   ____

   Did a doctor prescribe an EpiPen? Yes No
   (If yes, <u>provide an EpiPen for in-school use)</u>

7. I understand that the information provided on this form is confidential. I agree to allow the nurse to share this information with others who have a need to know to insure a safe environment for my child.
   (<u>Circle</u> answer) Yes No

The school doctor has written standing orders for the following medications to be given by the school nurse, when needed:

<u>CIRCLE EACH</u> medication which may be given to your child. (Generic equivalent products may be provided).

Advil Antacid Tablet Benadryl Imodium Sudafed (non-drowsy) Tylenol

<u>CIRCLE EACH</u> topical product below which may be applied to your child:

A & D ointment	Antiseptic throat spray	Hydrocortisone cream	Sting Relief
Anbesol/Campho-phenique	Burn cream/spray	Moisturizing eye drops	Visine eye drops
Antibiotic ointment	Caladryl lotion	Muscle Rub (BenGay)	

( ) Check here if you **DO NOT** wish to have any of the above medications administered to your child.

( ) My child is allergic to the following medication (s): ____

Please update the nurse with a written physician's copy of immunizations as they are received during the year.

School Law requires students to provide proof of having had one **<u>Physical Examination between September 1 of their sophomore year and June 1 of their junior year</u>**.

Please initial your preference below:
(   ) I would like my child to receive this examination in school, at no charge to me.
(   ) I will have my child examined by my Family Physician. (Forms are available on-line at www.qcsd.org).

Parent Signature ____________________________ **Print Name**______________________ **Date** _______________
I give permission for the school nurse to give my child the medications indicated above.