QUAKERTOWN COMMUNITY SCHOOL DISTRICT ANNUAL HEALTH UPDATE

2022-2023 School Year

Student Name:_____

Date of Birth:_____ **Grade:**_____ **Homeroom Teacher (elementary):**_____

1. Within the past year, has your child experienced a serious illness or injury? Yes ☐ No☐
2. Within the past year, has your child required ongoing treatment or surgery? Yes ☐ No☐

If you answered yes to the above questions, please explain:_____

_____

SPECIAL HEALTH CARE PLANNING ☐ **My child has NONE of these concerns/conditions listed below.**

☐ **Diabetes-** Type 1☐ Type 2 ☐ **My student has:** ☐ insulin pump ☐ insulin pen ☐ injected insulin

☐ **Seizure Disorder**- My student needs emergency medication for **Seizures.** Yes☐ No☐

Name of medication:_____

☐**Asthma**:

Yes☐ No☐ Does your child use a rescue inhaler routinely for asthma symptoms?

Yes☐ No☐ Does your child require an inhaler prior to P.E. class?

Yes☐ No☐ Will your child be self-carrying their inhaler (secondary students only)?

☐**Allergy/Anaphylaxis** -*Severe, with EpiPen/Auvi Q prescription (example: food, insect stings)

Allergen(s):_____

Yes☐ No☐ Will your child be self-carrying their Epinephrine (secondary students only)?

***If you answered yes to any of the above conditions, please provide the nurse with your child's Prescription and the Emergency Care Plan from the Physician.**

HEALTH CONDITIONS ☐ **My child has NONE of these concerns/conditions listed below.**

☐ Asthma	☐ADD/ADHD	☐Seasonal Allergies	☐Arthritis/Rheumatic Dx	☐Cystic Fibrosis
☐Cardiovascular Condition	☐Blood Disorder	☐ Cerebral Palsy	☐ Sickle Cell	☐ Spina Bifida
☐Tourette's Syndrome	☐ GI disorder	☐ Other (please list):		

The school doctor has written standing orders for the following medications. Please circle yes to give the school nurse permission to administer the following medications as needed:

Acetaminophen (Tylenol)	Yes	No	Anbesol topical	Yes	No
Antacid	Yes	No	Burn Cream gel/spray	Yes	No
Benadryl (Emergency only)	Yes	No	Caladryl Lotion	Yes	No
Hydrocortisone Cream	Yes	No	Ibuprofen (Motrin/Advil)	Yes	No
Moisturizing Eye Drops	Yes	No	Sting Relief Spray/Towelette	Yes	No

☐**I do not wish for my child to have any of these medications**

Is your child currently taking any medication? (Either at home or at school) If yes, please complete:

Name of Medication:_____**Dosage & Time given**_____**Reason:**_____

DENTAL AND HEALTH SCREENINGS:

My child's last dental exam was on (month, day, year) _____ **by (dentist's name)** _____

My child's last physical exam was on (month, day year) _____ **by (doctor's name)** _____

***IF YOUR CHILD HAS A LIFE THREATENING CONDITION OR REQUIRES A DAILY MEDICATION PLEASE REACH OUT TO YOUR CHILD'S NURSE TO DISCUSS THE PLAN OF CARE.**

Parent Signature_____**Date**_____

I give the school nurse permission to share health concerns/conditions with pertinent school staff (Initial here) _____

Revised 5/2021