ANTIETAM SCHOOL DISTRICT HEALTH INFORMATION- 2025/2026

Student Name: _____ **Birth Date:** ____/____/_____
Last **First**

Address: _____

Grade_____ Homeroom Teacher_____ Male____ Female____

RESIDES WITH: ☐ BOTH PARENTS ☐ FATHER ☐ MOTHER ☐ GUARDIAN

Father/Guardian *Check number to call first* **Mother/Guardian:**

NAME_____ NAME _____

E-MAIL _____ E-MAIL _____
HOME #_____ ◯ **Call 1st** HOME #_____ ◯ **Call 1st**
WORK#_____ ◯ **Call 1st** WORK #_____ ◯ **Call 1st**
CELL #_____ ◯ **Call 1st** CELL #_____ ◯ **Call 1st**

2- LOCAL contacts who will assume TEMPORARY care if parent/guardian CANNOT be reached:

Name	**Relationship**	**Phone #'s**	
1._____		1._____	2._____
2._____		1._____	2._____

PHYSICIAN_____PHONE #_____
DENTIST_____PHONE #_____

Are there any HEALTH CONCERNS the school nurse should be aware of?

CHECK ALL THAT APPLY	**YES**	**NO**		**YES**	**NO**
Arthritis/Rheumatic Disease			Eating Disorder		
Asthma			Emotional Problems		
Requires Inhaler at school (*will need a doctor's order)	*		Family History of Sudden Death		
Attention Deficit Disorder/Hyperactivity			Hearing Loss		
Taking medication for ADHD?			History of Fainting		
Bleeding Disorder			Orthopedic Problems		
Cancer			Seizure Disorder		
Cardiovascular Condition			Sickle Cell Disease		
Cerebral Palsy			Spina Bifida		
Cystic Fibrosis			Tourette's Syndrome		
Diabetes- Type I / Type II			Vision Concerns		
Digestive Disorders (IBS/GERD/CROHN's)			**MY CHILD WEARS:** *(please circle yes/no)* Glasses- YES NO Contact lens- YES NO Hearing Aides- YES NO		

PLEASE COMPLETE THE FOLLOWING SECTION RELATING TO MEDICATIONS YOUR CHILD RECEIVES
Daily or as needed, including medications taken at home. If required at school, must have medication order from physician.

Medication Name Time Reason for Use

1._____

2._____

PLEASE COMPLETE BOTH SIDES

List siblings or any other district students living in same house:

_____/_____/_____/_____

(Name & grade) (Name & grade) (Name & grade) (Name & grade)

I give the nurse permission to assess and treat my child accordingly, which may include administering the following medications as needed: Acetaminophen, Ibuprofen*, throat lozenge, throat spray, antacid, antihistamine, Pepto or Oragel.

For life threatening allergic reactions injectable adrenaline (Epi-Pen) will be administered

Antihistamine are for allergic reactions Only

(Please draw a line through any individual medications you do **not** wish to give permission to administer)

*Ibuprofen is limited to 2 doses weekly without specific written physician permission.

I GIVE PERMISSION: YES ◯ NO ◯

Is your child **ALLERGIC** to: **BEE stings?** YES/ NO **Medications?** YES/ NO **Latex?** YES/ NO

If **YES, describe reaction and treatment:** _____

Is your child **ALLERGIC** to: **PEANUTS?** YES/ NO **TREE NUTS?** YES/ NO

Is your child **ALLERGIC** to any other **FOOD /SUBSTANCE?** YES / NO

If **YES**, please list food, the reaction and the usual treatment: _____

_____

DOES YOUR CHILD REQUIRE AN EPI-PEN AT SCHOOL? YES / NO

***If your child requires an Epi-pen at school, for the treatment of a known allergy, it is the parent/guardians responsibility to provide the school nurse with the Epi-pen and physician orders for usage.**

For food allergies only:

Will your child be eating food served in the cafeteria**?** YES / NO

Is your child able to self-monitor to avoid exposure to their food allergen**?** YES/ NO

**Food allergies being "self-monitored" will not be recorded in cafeteria's POS (point of sale) system.*

*ALL Kindergarten/1ST, 3RD, 6TH, 7TH, 11TH grades - MUST COMPLETE!

The state of Pennsylvania mandates all students entering school in Kindergarten /1st grade, 6th grade and 11th grade, verify having a physical exam and all students entering school in Kindergarten /1st grade, 3rd grade and 7th grade verify having a dental exam.

It is recommended that your family dentist/physician do this examination, as he or she can assist you in any treatments or corrections that may be necessary. In addition, your child may be more comfortable in that setting. An examination performed any time **after July 1,2024** is acceptable. The private dental/physical form is available on the school website or in the nurse's office**. Please return the completed private dental/physical form by September 30, 2025**. If you prefer to have your child examined by the school dentist/physician a basic dental or physical examination will be done during this school year.

☐ I prefer to have my family dentist/physician perform the exam and will return **the completed form by September 30, 2025**. I understand if the form is not received by the school nurse my son/daughter will be scheduled for a school dental/physical exam.

In the event of an emergency, when parents and/or emergency contacts cannot be reached, I give permission to school authorities to use their judgment in obtaining the needed care for this student. I understand, any cost incurred will be the responsibility of the parent/guardian.

I have reviewed/completed both side of this form and agree to update the school nurse with any changes.

Signature of Parent/Guardian_____Date_____