SEVEN GENERATIONS CHARTER SCHOOL

Annual Health Update Form 2016-2017

Student Name: ______________________________ **Grade:** ______ **Teacher:** __________________

1. **Within the past year** has your child experienced a serious illness or injury? **(Circle answer)** Yes No

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

3. Does your child have any of the following?
Circle 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)? (Circle 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). **Circle answer)** Yes No

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

6. Has your child had a **SERIOUS ALLERGIC** reaction (requiring **HOSPITALIZATION** or **EMERGENCY ROOM CARE**) for the following?

Food Allergies: List symptoms and history of treatment.
____

Insect Allergies:
____

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

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 ensure a safe environment for my child. **(Circle answer)** Yes No

The school doctor has written standing orders for the following medications to be given by the school nurse, when needed:
CIRCLE EACH medication which may be given to your child. (Generic equivalent products may be provided.)

Advil Antacid Tablet Benadryl Tylenol

CIRCLE EACH topical product below which may be applied to your child:

Hydrocortisone cream Antibiotic Cream Caladryl lotion

( ) 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. If claiming exemption from physical exams, dental exams, and immunizations, please provide a written letter of objection to the school nurse.
School Law requires students **entering a Pennsylvania school for the first time** to have a physical and dental exam. Additionally, a physical is required **in sixth grade,** and dental exam is required **in third grade.**
The dental and physical exams must be performed after September 1st of the year prior to the required grade (student's original entry, third grade, and sixth grade).

Please submit ALL forms as early in the school year as possible.

Parent Signature ________________________ **Print Name** ____________________ **Date** ______________
I give permission for the school nurse to give my child the medications indicated above.