Big Spring School District Health Services
Annual Health Survey
High School Nurse 717-776-2450

Parents/Guardians: Please complete this **form and the attached permission form** to help the school nurse plan for the health needs of your student and facilitate their educational experience. Please feel free to call the nurse with questions

STUDENT NAME:_____ **GRADE:**_____ **Birthdate:** _____

First Emergency Contact during the Day: NAME:_____
BEST NUMBER:_____
BEST EMAIL ADDRESS:_____

PLEASE LOG INTO ASPEN AND MAKE SURE ALL CONTACT AND EMERGENCY INFORMATION AND TELEPHONE NUMBERS ARE CURRENT~ Thank You ☺

PHYSICIAN:_____ **DENTIST**:_____

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

Yes		**No**	Is your student covered by Medical Insurance? Name of Insurance Company:
Yes		**No**	ADD/ADHD:
			Is medication given at home? What? Is medication ordered to be given at school*?
Yes		**No**	Medication (s)* presently used at home and/or at school and the reason:
Yes		**No**	Asthma: Treatment required at school: Rescue inhaler*? Nebulizer*?
Yes		**No**	Bee/Insect Sting Allergy: Treatment required at school: Benadryl*? Epinephrine (Epi-pen)*?
Yes		**No**	If I can not be contacted and my student's temperature is over 101◦ administer **Tylenol _____ Ibuprofen** _____
Yes		**No**	Changes in the family during the past year which may affect school performance
Yes		**No**	Chronic or recurring condition or diagnosis, please explain:
Yes		**No**	Condition limiting Activity or Physical Education, please explain:
Yes		**No**	Diabetes
Yes		**No**	Drug/Medication Allergy, explain:
Yes		**No**	Food Allergy, explain:
Yes		**No**	Frequent Headaches or Migraines
Yes		**No**	Past history of concussion: If yes? DATE:
Yes		**No**	Hearing Problem or Vision Problem, please explain:
Yes		**No**	Heart or Cardiac Problem, please explain:
Yes		**No**	Lactose Intolerance
Yes		**No**	Seizure Disorder/Epilepsy, please explain: Date of last seizure? Able to swim?
Yes		**No**	Special dietary needs, please explain:
Yes		**No**	Surgery in the past year or other condition requiring ongoing care by physician

A **medication permission form completed by a physician and parent is needed for inhaler use and medications given at school. A form should be completed by the parent for over the counter medications.*

I give my permission to the school nurse or her designee to administer the following medications to my child, ONCE during the school day, according to the school's standing medical orders and I understand that a parent/guardian will be contacted for permission if more than one dose is needed on any given day. Please circle **YES or No** for each medication listed below.

YES	**NO**	Acetaminophen/Tylenol 325mg-1000mg
YES	**NO**	Antacids (Tums, Maalox, Mylanta)
YES	**NO**	Ibuprofen/Advil 200mg-400mg

- 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: Epi-pens, Benadryl, sting swab, triple antibiotic ointment, eye wash, alcohol drops for after swimming, calagel/calamine, hydrocortisone cream 1%, saline eye solution for contacts, cough drops, coke syrup, hydrogen peroxide, burn gel, throat spray, or oral gel, analgesic balm, or aloe gel. 2017-18 Medical Standing Orders are available for your review.
- Permission is given to the School Nurse **to conduct mandated health screening procedures** to assess vision, growth (height and weight), posture/spine, hearing, scalp/hair for pediculosis (head lice), school physical and/or dental exam.
- Over the counter medication like Tylenol and Advil 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 and grade**. Cough drops may also be brought to school for student use during the cold season. **Prescription medication administration requires a physician's order**.

Date:

Parent/Guardian Signature: _____ _____

9th Grade – Green; **10th** Grade –Yellow; **11th** Grade –Blue; **12th** Grade– Pink

HEALTH OFFICE USE ONLY
Big Spring Elementary School
Student Health Room Log of Visits

Student _______________ Grade/Section _______________ Page # _______

S.O.P. (Standard Operating Procedure) T.A.O. (topical antibiotic)

Date	In	Reason for Visit	Care Provided	Out	Initial
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
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Nurse Initial/Name:

_______________ _______________ _______________

_______________ _______________ _______________

Nursing Procedure	Nebulizer	BP check	Auscultation lungs	Exam ears - otoscope	Catheterize	Tube feeding	Diabetic management

PERMISSION FOR INFORMATION TO BE SHARED WITH BUS DRIVERS

Student's Name:_____ Grade _____ Bus Number:_____

We are offering parents and guardians of each student the opportunity to provide bus drivers with any information that may be appropriate. The information will be retained by the driver and held in confidence. Please complete the section below. The school will distribute the information to the appropriate driver. Thank you for your cooperation.

_____ **I have no medical information regarding my child that is to be shared with the bus driver.**

_____ **I wish to make my student's bus driver aware of the following medical information:**

_____

_____

_____

_____

_____

Grade Birthdate

Student Name: _____ _____ _____

++++++++++++++**ATTENTION 11th Grade Students AND NEW STUDENT PARENTS**++++++++++++

PHYSICAL EXAMINATION PERMISSION

The Pennsylvania School Health Act requires a medical examination for children in 11th GRADE and students 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 you 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 physicians, 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. Examinations are usually scheduled during the second half of the school year. You will receive a notice when the examination will be completed and you are welcome to be present for the examination.

_____ **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. _____ on _____2017 or 2018 (please provide date of appointment).**

Parent/Guardian Signature _____Date_____