Big Spring School District Health Services
Annual Health Survey
Mt. Rock 776-2425 **Newville** 776-2435 **Oak Flat** 776-2445
Kind.-yellow **1st grade** – Blue **2nd grade** – green **3rd grade** – pink **4th grade** – tan **5th grade** - grey

To Parents or Guardians: Please complete the **front side of 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'S NAME_____**GRADE**_____Birthdate_____
Address: _____

MOTHER'S NAME:		**FATHER'S NAME:**	
Mother's home #		Father's home #	
Mother's Work #		Father's Work #	
Mother's Cell #		Father's Cell #	
E-mail address		E-mail address	

Student lives with _____

Emergency Contacts: PLEASE LIST PERSONS AVAILABLE DURING THE DAY

1. **Name** _____ **Phone Number** _____
2. **Name** _____ **Phone Number** _____
3. **Name** _____ **Phone Number** _____

Please list other children in the family

Name _____ Grade _____ Building _____
Name _____ Grade _____ Building _____
Name _____ Grade _____ Building _____

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

Yes		**No**	ADD/ADHD:
			Is medication given at home? What? Is medication ordered to be given at school*?
Yes		**No**	Medication (s)* presently used 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**	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:
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.*

Parental Permission

- **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, as needed.**
- Permission is given for the use of other first aid supplies used in the health room including: Epipens, Benadryl, sting swab, triple antibiotic ointment, eye wash, alcohol drops for after swimming, calagel/calamine, saline eye solution for contacts, coke syrup, hydrogen peroxide, burn gel, throat spray, or oral gel. 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, grade, and teacher's name. Cough drops may also be brought to school for student use during the cold season. Prescription medication administration requires a physician's order.

Parent/Guardian Signature: _____ Date: _____

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

Student ______ Grade/Section ______ Page # ______

S.O.P. (Standard Operating Procedure)

Date	In	Reason for Visit	Care Provided	Out	Initial
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
				❑ To Class @ ❑ Recheck @ ❑ Home with:	
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Parent Notified of Health Room Visits

Notes:

Cough Drop Pass issued: ______________________________

Nurse Initial/Name:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Nursing Procedure	Nebulizer	Stoma Care	Auscultation lungs	Exam ears - otoscope	Catheterize	Tube feeding	Diabetic management

Student Name: _____ Grade _____ Birthdate _____

School administration of fluoride tablets:

Your child has a unique opportunity to take advantage of a continuing project this year at Big Spring School District. In order to reduce tooth decay, we are offering a fluoride tablet free each school day to children in the elementary grades. Dr. Thomas Filip, school examining dentist has approved this project for the welfare of the children's dental health.

If your child has received fluoride treatments from your dentist, he can still get added protection from the tablets.
If your child takes a vitamin tablet with fluoride added, or a fluoride tablet, he/she should not take the tablet in school.
Please complete and sign the permission section below indicating your decision.

_____ **I give permission for my child, _____, to receive one fluoride tablet each school day this year.**

_____ **I DO NOT GIVE PERMISSION for my child to receive fluoride tablets at school this year.**

Parent/Guardian Signature _____Date_____

++++++++++++**ATTENTION FIRST AND THIRD GRADE PARENTS**++++++++++++++++

DENTAL EXAMINATION PERMISSION

The Pennsylvania School Health Act requires a dental examination for children in the **first**, **third**, and seventh grades. We encourage that this be completed by your family dentist and reported to the school. However, the school dentist can do this exam.

If you would like a dental examination done at school this year by our school dentist, Dr. Filip, 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 first 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 dentist, Dr. Thomas Filip.**

_____ **I DO NOT GIVE PERMISSION for my child to be examined by the school dentist. I will schedule an appointment with my child's dentist, Dr. _____.**

Parent/Guardian Signature _____Date_____

PERMISSION FOR INFORMATION TO BE SHARED WITH BUS DRIVERS

Student's Name:_____ 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:**

_____

_____

_____

_____

_____

Student Name: _____ Grade _____ Birthdate _____

++++++++++++++**ATTENTION KINDERGARTEN AND NEW STUDENT PARENTS**++++++++++++

PHYSICAL EXAMINATION PERMISSION

The Pennsylvania School Health Act requires a medical examination for children on original entry (KINDERGARTEN/FIRST GRADE) and 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.**

_____ **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. _____.**

_____ **I give permission for my child, _____, to be transported in a school vehicle with staff to the elementary school where Dr. Darryl Guistwite will be performing physical examinations.**

_____ **I DO NOT GIVE PERMISSION for my child to be transported in a school vehicle with staff to the elementary school where Dr. Guistwite will be performing physical examinations.**

Parent/Guardian Signature _____Date_____