SCHUYLKILL TECHNOLOGY CENTER

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Student Health Information/Permission Form

STUDENT NAME: _____ ***SCHOOL YEAR*** _____

DATE OF BIRTH: _____ ***SHOP:*** _____ ***GRADE***_____

Dear Parent/Guardian:

Please complete this form and return it to the school. The information provided will assist school personnel in the care of your child and will only be shared with school staff when the school nurse/physician believes it would be beneficial to your child's health and education. This form will be filed in your child's school health record.

Guardian: _____

Telephone #: _____
Please provide a phone number where the guardian may be reached between 8am and 3 pm.

Email address: _____
(May we send information to you at this email address? _____)

Physician's Name_____ ***Phone #***_____

Please list all siblings still in school:

Name: _____ Grade: _____ School: _____

Name: _____ Grade: _____ School: _____

Name: _____ Grade: _____ School: _____

Name: _____ Grade:_____ School:_____

Health Conditions (for ex: asthma, diabetes, seizures, ADHD) _____

_____

please complete other side

Allergies (type of **reaction)**: _____

Treatment for allergic reaction (Bendadryl, Epipen, etc)_____

_____

Medications (prescription/over the counter) **and Reason**: _____

_____

Surgeries**:** _____

Recent immunizations (for example, **tetanus**) ***and date given:***

_____

Special needs that affect physical activity or education (vision, hearing, or mobility problems):

_____

My child may receive the following pain relievers for minor discomfort:

Tylenol _____Yes _____No **Ibuprofen** _____YES _____NO

Midol _____ Yes_____ No **(girls only)**

My child may receive the following mediation for relief of sinus congestion:

Claritin _____Yes _____ NO
(medication may be generic)

My child may receive **Pepto-Bismol** for nausea, diarrhea _____YES_____NO

My child may receive **antacids** for relief of minor stomach upset _____YES _____ NO

My child may receive **Benadryl** for allergies or rash _____YES _____NO

My child may receive care of minor injuries (bruises, cuts) _____YES _____ NO

***** PLEASE NOTE*****:** Any medications that the student must take in school must be accompanied by a written prescription **OR** parent note AND **must be in the original container.** No meds will be administered if these guidelines are not followed. Thank you for your cooperation.

_____ _____

Parent/Guardian Signature ***Date***

Revised 12/2012