

QUAKERTOWN COMMUNITY SCHOOL DISTRICT ANNUAL HEALTH UPDATE

2021-2022 School Year

Student Name: _____

Date of Birth: _____ Grade: _____ Homeroom Teacher (elementary): _____

- 1. Within the past year, has your child experienced a serious illness or injury? Yes No
 - 2. Within the past year, has your child required ongoing treatment or surgery? Yes No
- If you answered yes to the above questions, please explain: _____

SPECIAL HEALTH CARE PLANNING My child has NONE of these concerns/conditions listed below.

- Diabetes-** Type 1 Type 2 My student has: insulin pump insulin pen injected insulin
 - Seizure Disorder-** My student needs emergency medication for **Seizures**. Yes No
- Name of medication: _____

- Asthma:**
- Yes No Does your child use a rescue inhaler routinely for asthma symptoms?
- Yes No Does your child require an inhaler prior to P.E. class?
- Yes No Will your child be self-carrying their inhaler (secondary students only)?

- Allergy/Anaphylaxis** - *Severe, with EpiPen/Auvi Q prescription (example: food, insect stings)
- Allergen(s): _____
- Yes No Will your child be self-carrying their Epinephrine (secondary students only)?

***If you answered yes to any of the above conditions, please provide the nurse with your child's Prescription and the Emergency Care Plan from the Physician.**

HEALTH CONDITIONS My child has NONE of these concerns/conditions listed below.

<input type="checkbox"/> Asthma	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Arthritis/Rheumatic Dx	<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Cardiovascular Condition	<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Tourette's Syndrome	<input type="checkbox"/> GI disorder	<input type="checkbox"/> Other (please list): _____		

The school doctor has written standing orders for the following medications. Please circle yes to give the school nurse permission to administer the following medications as needed:

Acetaminophen (Tylenol)	Yes	No	Anbesol topical	Yes	No
Antacid	Yes	No	Burn Cream gel/spray	Yes	No
Benadryl (Emergency only)	Yes	No	Caladryl Lotion	Yes	No
Hydrocortisone Cream	Yes	No	Ibuprofen (Motrin/Advil)	Yes	No
Moisturizing Eye Drops	Yes	No	Sting Relief Spray/Towelette	Yes	No

I do not wish for my child to have any of these medications

Is your child currently taking any medication? (Either at home or at school) If yes, please complete:

Name of Medication: _____ Dosage & Time given _____ Reason: _____

DENTAL AND HEALTH SCREENINGS:

My child's last **dental exam** was on (month, day, year) _____ by (dentist's name) _____

My child's last **physical exam** was on (month, day, year) _____ by (doctor's name) _____

***IF YOUR CHILD HAS A LIFE THREATENING CONDITION OR REQUIRES A DAILY MEDICATION PLEASE REACH OUT TO YOUR CHILD'S NURSE TO DISCUSS THE PLAN OF CARE.**

Parent Signature _____ Date _____

I give the school nurse permission to share health concerns/conditions with pertinent school staff (Initial here) _____