

Bethel Park High School Health Office

309 Church Road • Bethel Park, PA 15102

(412) 854-8550

Dear Parent/Guardian,

As the High School Nurse, my first concern is the welfare of each student. To be able to assist the student during an illness or an emergency, it is important for you to complete the following forms:

- **EMERGENCY FORM** - This form must be completed by the parent/guardian. Phone numbers will *not* be accepted from students. Parents are strongly encouraged to update this information as changes occur throughout the year. Phone numbers may be updated by contacting the nurse at the number listed above or by submitting a request for change in writing.

This form also includes standing order medications (Tylenol, Ibuprofen, Tums and Benadryl) that are available in the health office in the event your student becomes ill during the school day. In order for this medication to be administered, we must have written consent. Therefore, please be sure to sign the form. *Verbal/phone consent will not be accepted.* These medications can only be given up to 3 times during the school year. Once your son/daughter reaches their allotted doses of standing order medication, a Medication Form will be sent home.

- **MEDICATION FORM** - This form must be completed by the parent/guardian *and* the student's physician for any and all medication (prescribed and over-the-counter) that will be taken during the school day. **NO MEDICATION**, including over-the-counter medication is to be carried by the student. Medication will *only* be accepted and administered when it is in the original container or prescription bottle.
- **HEALTH HISTORY FORM** - *9th Graders and New Students only.* This is a 2-page form. Please complete and sign this form in order for the nurse to meet any health/medical needs your student may have.

The Health Office is open daily from 7:30 a.m. to 2:35 p.m. When ill, students are permitted to rest **15 minutes** and are then encouraged to return to class. If a student is unable to return to class, we will attempt to reach the parent/guardian first, unless otherwise indicated, then the emergency contacts listed on the Emergency Form. *Only the names and numbers listed on the Emergency Form will be contacted.*

Sincerely,

Tracy Ford, MSN, CRNP

Certified School Nurse Facilitator

HEALTH OFFICE EMERGENCY CARD – Parents should **SIGN BELOW**

Student's Name _____ Birthdate _____ Grade/Room ____ / ____
Last First Middle Initial

Address _____ Zip _____ Male ____ Female ____

Father's Name _____ Home# (____) _____ E-Mail _____

Work _____

Employer's Name _____ Hours _____ Work# (____) _____ Cell# (____) _____

Mother's Name _____ Home# (____) _____ E-Mail _____

Work _____

Employer's Name _____ Hours _____ Work# (____) _____ Cell# (____) _____

List names & relationship of all that live with student _____

Name at least **THREE** relatives or friends to contact when parent is unavailable during a student illness, injury, or emergency.
PERSON MUST DRIVE AND BE ABLE TO PICK UP STUDENT DURING THE DAY.

Name _____ Relationship _____ Phone# (____) _____ Cell# (____) _____

Name _____ Relationship _____ Phone# (____) _____ Cell# (____) _____

Name _____ Relationship _____ Phone# (____) _____ Cell# (____) _____

During an emergency, the Emergency Medical Services (EMS-ambulance) will transport the student to a hospital or special facility deemed necessary for the emergency. Since an emergency can occur at any time, requiring us to call the EMS, it is **VERY IMPORTANT** that the certified school nurse be informed if your child has any of the following:

1) **ANY EXISTING MEDICAL OR EMOTIONAL CONDITION(S)**

2) **A NEWLY DIAGNOSED CONDITION(S)**

3) **ANY CHANGE IN A CONDITION**

4) The name of **ANY MEDICINE** taken regularly at home or that will need to be taken in school.

For the safety of all students, **NO MEDICINE** (prescription or over-the-counter), is permitted to be carried by the student.

Doctor's Name _____ Phone (____) _____

Dentist's Name _____ Phone (____) _____

If your child **does not** have Health, Dental, or Vision Insurance, information is available on free or low cost coverage. Check the information you would like the school nurse to send you: _____ Health Insurance _____ Dental Insurance _____ Vision Coverage

List **ANY** medical and/or emotional condition(s) your child has _____

List **ANY** allergies _____ Treatment for allergies _____

List **ANY** medicine taken regularly at home _____ Time taken _____

List **ANY** medicine child is to take in school (requires a doctor's order) _____ Time to be taken _____

The following medicines are available through the Health Office and if you check any below, the medicine will be given at manufacturer's directions for age/weight & dose. If your child requires the Health Office medicine more than 3 times, the child's doctor would then need to order medicine to be given at school, the parent/guardian would need to complete the school's Medication Form, and the parent/guardian would need to provide the medicine in the original medication container. Check the medicine you permit your child to receive up to 3 times in the Health Office:

- | | | | | |
|---|-------|-----|-------|----|
| 1. Acetaminophen (e.g. Tylenol) | _____ | Yes | _____ | No |
| 2. Ibuprofen (e.g. Advil, Motrin) | _____ | Yes | _____ | No |
| 3. Antacid (e.g. Tums, Mylanta, Maalox) | _____ | Yes | _____ | No |
| 4. Benadryl | _____ | Yes | _____ | No |

Signature of Parent/Guardian _____

Date _____

BETHEL PARK SCHOOL DISTRICT

BETHEL PARK HIGH SCHOOL HEALTH OFFICE

9TH GRADE AND ENTERING STUDENT'S HEALTH HISTORY

The Bethel Park School District requests that the parents/guardians of all 9th graders and incoming students complete the following confidential Health History (**2 pages**) to help the school nurse develop a Care Plan for your child, should your child need medical, physical, emotional, social and/or academic assistance. If you have any questions, please feel free to contact the school nurse.

Student's Name _____ Birth Date _____ Grade _____ Sex _____
Home Address _____ City _____ Zip _____ Home Phone _____

Student Lives with: Both Parents Mother Step-mother Father Step-father Guardian Other
Father's Name _____ Work # _____ Cell # _____
Mother's Name _____ Work # _____ Cell # _____
Guardian's Name _____ Work # _____ Cell # _____

List all people living in household:

Name	Sex	Relationship to Student	Occupation or Grade/Age (if sibling)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Name of last school attended _____ Phone # _____
Address _____ City _____ State _____ Zip _____

The Pennsylvania Department of School Health requires a physical examination in grades K, 6 and 11. They also require a dental examination in grades 3 and 7. These examinations are also required for those students with incomplete health records. The examinations will be accepted if completed one year before the required grade.

*Please indicate below your preference for the completion of the mandated physical and/or dental examinations. If you choose to have your student seen by the school district's dentist or physician, it will be **FREE** and of no cost to you.*

I prefer our **PRIVATE PHYSICIAN/DENTIST** to do the physical/dental examination.
DATE OF EXAMINATION(S): Physical _____ **Dental** _____

I prefer the **SCHOOL PHYSICIAN** do the physical examination.

I prefer the **SCHOOL DENTIST** to do the dental examination.

If you do not have Health Insurance, Dental Insurance and/or Vision Insurance, the school nurse can share information with you regarding free/low cost dental, vision and health care.

Would you like for the nurse to send you this information? Yes No

Please check if your student FREQUENTLY experiences any of the following:

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Poor sleep patterns | <input type="checkbox"/> Poor eating patterns |
| <input type="checkbox"/> Colds | <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Difficulty breathing through nose |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stammering/Stuttering | <input type="checkbox"/> Breathless with activity |
| <input type="checkbox"/> Urination | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Persistent coughing | <input type="checkbox"/> Pains in arms/legs |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Earaches/drainage | <input type="checkbox"/> Stumbles or drops things |

Medical History – Please check all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Abnormal Blood Lead Levels | <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Orthopedic Condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical/Hormonal Imbalance | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Color Vision Deficit/Blindness | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Psychiatric Condition |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Connective Tissue Disorder | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Drug/Tobacco/Alcohol Usage | <input type="checkbox"/> Head/Neck Injury | <input type="checkbox"/> Short Stature |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emotional/Behavioral Condition | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Joint/Bone/Muscle Problem | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Immunosuppressive Disorder | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Dental Condition | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuromuscular Disorder | <input type="checkbox"/> Lung Condition | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dietary Restrictions | <input type="checkbox"/> Stomach/Intestinal Disorder | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Underweight |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> Overweight | <input type="checkbox"/> Other _____ |

Explain condition(s) checked above or any other medical condition(s): _____

Allergies: Food Insect/Bee Medication Plants Animals Seasonal Environmental Other _____
Specify allergy(ies), reaction(s) and treatment(s) _____

Hearing/Ear Problems: Yes No. If yes, type _____ Tubes? Yes No Hearing aide(s)? Yes No

Vision Problems: Yes No. If yes, diagnosis _____ Wears glasses/contacts? Yes No

Recurring illness/infection: Yes No. If yes, explain _____

List major injuries, operations and/or hospitalizations: _____

Does any of the above prevent full participation in any school or physical education program? Yes No

If yes, explain: _____

List medication(s) taken at home regularly _____

List any medication to be taken at school _____

May the school staff be informed of your student's health history? Yes No

Would you like a conference with the school nurse? Yes No

Parent/Guardian Signature _____ **Date** _____