Pope John Paul II High School
HEALTH/EMERGENCY INFORMATION

Last First

NAME_____**BIRTH DATE**____/____/_____

GRADE_____ HOME ROOM #/TEACHER_____/_____MALE ___ FEMALE____

ADDRESS: _____

RESIDES WITH: BOTH PARENTS: ☐ FATHER:☐ MOTHER: ☐ GUARDIAN: ☐

Father/Guardian *Check number to call first*	**Mother/Guardian:**
NAME_____	NAME_____
HOME #_____ ☐**Call 1st**	HOME #_____ ☐**Call 1st**
WORK #_____ ☐**Call 1st**	WORK #_____ ☐**Call 1st**
CELL # _____ ☐**Call 1st**	CELL # _____ ☐**Call 1st**

****Parent/Guardian EMAIL**_____

IN THE EVENT THE PARENT/GUARDIAN CANNOT BE REACHED LIST 2 LOCAL CONTACTS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD:

Name	**Relationship**	**Phone #'s**
1._____	1._____	2._____
2._____	1._____	2._____

PHYSICIAN_____ PHONE #_____

DENTIST_____ PHONE#_____

MEDICATION: The nurse, or designate, is the only person authorized to administer medications. All medication brought to school must be accompanied by an *Authorization for School Medication Administration Form* which must be completed in full. This form can be accessed at pjphs.org. Medication must be received in the original packaging with label including child name, medication name, dosage, prescribing physician, date, and directions for use. All non-prescription medications will be dispensed according to the recommended dosage on the package.

STUDENT HEALTH CONCERNS/MEDICAL HISTORY

Is your child **ALLERGIC** to **BEE stings**? YES ☐ NO ☐ **INSECT bites?** YES ☐ NO ☐

Is your child **ALLERGIC** to **PEANUTS?** YES ☐ NO ☐ **TREE NUTS**? YES ☐ NO ☐

If **YES to above**: DESCRIBE **REACTION**_____

TREATMENT for REACTION_____

Is your child **ALLERGIC** to any OTHER **FOOD/DRUG/ SUBSTANCE**? YES ☐ NO ☐

IF **YES**, what foods, drugs, substances? _____

If **YES**: DESCRIBE **REACTION**_____

TREATMENT for REACTION_____

*****IF your child requires an Epi-pen for the treatment of a known allergy, it is the parent/guardian responsibility to provide the school nurse with the Epi-pen and physician orders for usage.**

I give the school nurse or designated employee permission to administer the following over the counter medications as needed: Tylenol, Ibuprofen, Chloraseptic, Tums, and Benadryl, generic medications may be substituted. (Ibuprofen is limited to 2 doses weekly without written physician permission)

I GIVE PERMISSION: YES ☐ NO ☐

***For life threatening allergic reactions injectible Adrenaline (Epi-Pen) will be administered. ***

I give the school nurse or designated employee permission to administer potassium iodide (KI tab) when instructed by the governor or public health official in the event of a radioactive emergency during school hours.

I GIVE PERMISSION : YES ☐ NO ☐

Signature Parent/ Guardian: _____**Date:**_____

*****PLEASE COMPLETE BOTH SIDES*****

PLEASE COMPLETE THE FOLLOWING SECTION RELATING TO MEDICATIONS YOUR CHILD RECEIVES

Medication Name Time Reason for Use

1._____
2._____
3._____

Please list immunizations received in the past 12 months include dates given:_____
_____

CHECK ALL THAT APPLY	YES	NO		YES	NO
ARTHRITIS / RHEUMATIC DISEASE			EMOTIONAL PROBLEMS		
ASTHMA			FAMILY HISTORY OF SUDDEN DEATH		
ATTENTION DEFICIT DISORDER / HYPERACTIVITY			HEARING LOSS		
BLEEDING DISORDER			HISTORY OF FAINTING		
CANCER			ORTHOPEDIC PROBLEMS		
CARDIOVASCULAR CONDITION / PROLONGED QT SYNDROME			SEIZURE DISORDER		
CEREBRAL PALSY			SICKLE CELL DISEASE		
CYSTIC FIBROSIS			SPINA BIFIDA		
DIABETES TYPE I			TOURETTE'S SYNDROME		
DIABETES TYPE II			VISION CONCERNS		
DIGESTIVE DISORDERS (IBS/GERD/CROHN'S)			CONCUSSION(S)		
EATING DISORDER			OTHER HEALTH CONCERNS		

**If your child requires medication to treat asthma, complete the Use of Inhaler at School Form found on the website. This form requires physician and parent/guardian signatures.

BELOW PLEASE PROVIDE EXPLANATION OF MEDICAL CONDITION(S) CHECKED YES ABOVE:

MY CHILD WEARS:
Glasses: **YES** ☐ **NO** ☐ Contacts: **YES** ☐ **NO** ☐ Hearing Aides: **YES** ☐ **NO** ☐ Other_____

Parents of 11th Grade students please complete the section below

The state of Pennsylvania mandates all 11th grade students have a physical exam. It is recommended that your family physician do this examination, as he or she can assist you in any treatments or corrections that may be necessary. In addition, your child may be more comfortable in a setting he or she is familiar with. An examination performed anytime within one year prior to the current school year is acceptable.
The private physical form is available on the school website or in the nurse's office. Please return the completed private physical form by December. If you prefer to have your child examined by the school physician a basic physical examination will be done during this school year.

☐yes ☐no I prefer to have my family physician do the exam and will return the completed form by December of this school year. I understand if the form is not received by the school nurse my son/daughter will be scheduled for a school physical exam.
☐yes ☐no I prefer to have the school physician assistant examine my child.
☐yes ☐no I wish to attend the physical exam.

In case of an emergency, when parents or emergency contacts cannot be reached, I give permission to school authorities to use their judgment in obtaining care for this student. Any cost incurred will be the responsibility of the parent/guardian.
I have reviewed both sides of this card and will inform the school nurses' office with updates.

Signature of Parent/Guardian: _____**DATE**_____