DUE 7-15-11

Bryn Athyn Church School
Student Health History Form and Release of Information
School Year 2011 – 2012

Student Name______________________ **DOB** ____/_____/_______ ( ) M ( ) F
mon. day year

Pediatrician's Name ____

Address ____

Phone # ____

Your child's health history is important so that we can provide the best care at school. BACS administers student health screenings for vision, hearing, height, weight and BMI. If there is a new or existing health condition which affects a student's ability to participate in school activities, it is the responsibility of the parent/guardian to notify the school.

Medical / Surgical History

Condition	Yes	Condition	Yes	Condition	Yes
ADD / ADHD		Headache – Chronic / Migraine		Chronic / Severe Skin Problem	
Asthma - (Inhaler: Yes or No)		Heart Condition		Stomach or Intestinal Trouble	
Frequent Anxiety/Panic Attacks		Heart Murmur/Arrhythmia		Thyroid Condition	
Birth Defects		Hepatitis / Jaundice		Tumor, Cancer, Cyst	
Blood Disorder/hemophilia		Insomnia		Weight Concerns	
Brain Injury (i.e. CP, stroke)		Disease or injury of Joints		**Surgical history:**	
Concussion/Head Trauma		Heat related illness		Appendectomy	
Chronic Cough		High Blood Pressure		Tonsillectomy/Adenoidectomy	
Cystic Fibrosis		Kidney Disease		Hernia Repair	
Depression		Lactose Intolerance		Ear tubes	
Diabetes		Menstrual problems		Eye disorder/vision problems	
Dizziness / Fainting		Seasonal Allergy		Hearing problems	
Eating disorder		Seizures / Epilepsy		Other	

If you checked yes to any of these – please explain

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Recent Hospitalizations (within the last 3 years)

Please explain briefly____

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Communicable Diseases

(only provide date if your child has had one of these diseases)

	Month/year		Month/year		Month/year
Chicken Pox		Rheumatic Fever		Whooping Cough	
Measles		German Measles (Rubella)		Tuberculosis / TB Test	
Mumps		Febrile Seizures		Mononucleosis	
Pneumonia		Scarlet Fever			

Please turn over

Allergies

Allergy Types	Reaction	Treatment/Medications
Bee / Insect		
Drugs		
Food		
Pollen		
Skin		
Other (i.e.) latex		
Dietary Restrictions (please explain)		

Administration of Medication

Over the Counter Medications: see **Standing Order Form**

Prescription Medication

Prescription medication used during the school day requires a completed Medication Administration Form. All medications should be kept in the School Nurse Office. (7th & 8th grade students may be permitted to hand-carry prescribed emergency medications, such as an inhaler, Epi-pen, or diabetic products if the required medication form is completed by the student's health care provider and parent / guardian.)

Medication(s)	Dose	Times	Reason	Date prescribed	Prescribing Physician

Do any health and/or medical conditions require school restrictions, modifications, special procedures or treatments.

Yes No If yes, explain

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Emergency Permission to Treat: In the event that I cannot be reached, I hereby give my consent for emergency treatment for the above named BACS student according to the judgment of the school nurse or athletic director.

Parent Signature ____Date________________

Release of Information: The disclosure of health information within the school is limited to information necessary to serve the student's health and education interest. Your signature gives permission for the nurse to inform school staff of procedures to protect your child at school and develop emergency health plans, if required.

Parent(s)/Guardian(s) signature ____________________________________Date __________________