

Due 7-15-11

**Bryn Athyn Church School
Student Health History Form and Release of Information
for Returning Students
School Year 2011 - 2012**

Student Name (print) _____ DOB ___/___/___ () M () F

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.

Due to changes in the Pennsylvania immunization requirements we are requesting an update on every student's vaccine status. Please fill out the grid below or attach a copy of your child's immunization records.

| VACCINE | Enter Month, Day, And Year Each Immunization Was Given | | | BOOSTERS & DATES | |
|--|--|--------|-------|--|-------|
| | DOSES | | | | |
| Diphtheria and Tetanus (Circle): DTaP, DTP, DT, TD | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Polio (Circle): OPV, IPV | 1 / / | 2 / / | 3 / / | 4 / / | 5 / / |
| Measles, Mumps, Rubella | 1 / / | 2 / / | | | |
| Hepatitis B | 1 / / | 2 / / | 3 / / | | |
| HIB | 1 / / | 2 / / | 3 / / | | |
| Varicella (Chicken pox) | 1 / / | 2 / / | | Varicella Disease or Lab Evidence Date: _____ | |
| Menactra (Meningitis) | 1 | Other: | | | |

Medical / Surgery History

Has your child received a new medical diagnosis or had surgery in the last year? If so, please list below and include any pertinent information:

Hospitalizations

Has your child been hospitalized in the last year? If so, please explain:

Please turn over

Allergies

Has your child developed any allergies in the last year (bee/insect, drugs, food, pollen, skin, latex etc.)? If so, please describe the nature of the reaction and any treatments or medications given:

Does your child have any dietary restrictions? If so, please explain:

Administration of Medication

Over the Counter Medications: See Standing Order form

Prescription Medication: All prescription medication(s) used during the school day requires a completed Medication Administration Form (available in the nurse's office).

All medications should be kept in the School Nurse Office. (7th and 8th grade students may be permitted to hand carry prescribed emergency medications such as inhalers, Epi-pens or diabetic supplies if the required medication form is completed by the student's health care provider and parent/guardian).

Please list any prescription medications your child is on.

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

Yes No If yes, please explain: _____

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/Guardian 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/Guardian signature _____ Date _____