LINCOLN PARK PERFORMING ARTS CHARTER SCHOOL

Annual Health Form

Student _____ DOB_____ Grade _____ School Year_____

(Last) (First) (Middle Initial)

Home Address _____Student cell phone #_____

School District of residence_____ Last school attended (if new student)_____

Student lives with ❑ Mother ❑ Father ❑ Step-parent ❑ Grandparent ❑ Other:_____

Mother's Name _____ Home #_____Cell #_____
Mother's Employment _____ Phone# _____

Father's Name _____ Home #_____Cell #_____
Father's Employment _____ Phone# _____

Names and grades of brothers and sisters _____

Email 1_____ Email 2_____

Family Physician _____ Phone _____

Please list **Parent Substitutes** who can be contacted regarding student's care in the event a parent cannot be located. *PLEASE NOTE: Only those listed below will be permitted to pick up your child in case of illness or emergency, unless specified by parent/guardian. As per district policy, photo ID may be required.*

Name_____ Relation _____Phone_____

Name_____ Relation _____Phone_____

List anyone who is **NOT PERMITTED** to pick up your child from school:

Name _____ Name _____

Agree❑ Disagree❑ This is to certify that, I parent or guardian of the named student, herby grant permission for the adult supervisors to obtain medical care from any licensed physician, hospital or medical clinic for the student named herein at such time as either parent or guardian cannot be contacted in person or by phone. This authorization shall also include all activities, and we do hereby waive, release, absolve, indemnify, and agree to hold activity sponsors, organizers, supervisors and participants, for any claim arising out of injury to the student or accidents that may occur during the activity.

Agree❑ Disagree❑ Any student requiring emergency care will be transported via ambulance to the nearest hospital. If school representatives are unable to contact parent/guardian in the event of an emergency, the school will have the student transported by ambulance service to the nearest hospital.

Agree❑ Disagree❑ I give my permission for the school nurse to contact my child's physician for any medical concerns.

Agree❑ Disagree❑ I give permission for my child's health information to be shared with school staff and emergency personnel on a need to know basis.

PLEASE COMPLETE HEALTH INFORMATION ON BACK SIDE →

Health Information

ALERT TO PARENTS/GUARDIANS: If your child has a serious medical condition, **it is vital that you discuss this with the School Nurse immediately.** The school **must** know of **LIFE THREATING** conditions (for example allergy with anaphylaxis, diabetes, asthma or seizures) **prior** to the start of school. **All** necessary paperwork (physician order and parental consent form) **mus**t be on file for any medication necessary to treat the student prior to or on day of student's arrival.

Asthma requiring an inhaler Yes❑ No❑ **Severe Allergy** requiring Epi-Pen Yes❑ No❑

Allergy_____ **Diabetes** Yes❑ No❑ Uses a pump Yes❑ No❑

Seizure Disorder Yes❑ No❑ Takes medication Yes❑ No❑ Date of last seizure_____

ADHD Yes❑ No❑ Yes❑ No❑Medication:_____

Non-life threatening allergy Yes❑ No❑ ❑Food_____ ❑Medicine_____❑Other_____

Specify reaction to mild allergy or allergen: ❑Rash ❑Swelling ❑Hives ❑Vomiting ❑Local reaction❑ Other

Physical, developmental or behavioral issues that may affect his/her education: Yes❑ No❑

Explain_____

Please note any other health concerns/conditions_____

_____

MEDICATION

Please mark which OTC medications you permit the nurse to give your student as needed. LPPACS has "standing orders" written by the school physician for these medications (**with a limit)** that can be given.

Acetaminophen Yes❑ No❑ **Ibuprofen** Yes❑ No❑ **Antibiotic ointment** Yes❑ No❑ **TUMS** Yes❑ No❑

Anbesol/Oragel Yes❑ No❑ **Sting/burn gel** Yes❑ No❑ **Benadryl** Yes❑ No❑ (**severe allergic reaction only**)

The following screenings are mandated by Pennsylvania School Code. Please notify the school nurse annually in writing or by email if you do **not** wish to have the screenings done at school.

Vision:All grades **Hearing**:Grades 7 & 11 and all special ed students **Ht/Wt**: All grades **Scoliosis**:Grade 7

Yes❑ No❑ Does your child have medical health insurance?

Health Insurance Provider_____ Policy Number_____

Parent/Guardian Name (printed) _____ Relation_____

Signature_____ Date _____