**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**

Page 1

 **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Page 2