

KUTZTOWN SCHOOL DISTRICT HEALTH SERVICES ELEMENTARY SCHOOLS

Student Name _____ Grade _____ Birth Date _____

Address #1 _____ Address #2 _____

Telephone _____ Telephone _____

Child lives with Parents BOTH together () **OR *Father () *Mother () Other ()** _____
***CHECK MOTHER AND FATHER IF LIVES WITH BOTH SEPARATELY.**

If Foster Parents, Include Name: _____

Father's Name _____ Place of Employment _____

Father's Work Number (ext.) _____ Father's Cell Phone Number _____

Father's email: _____ Mother's email: _____

Mother's Name _____ Place of Employment _____

Mother's Work Number (ext.) _____ Mother's Cell Phone Number _____

If unable to reach parent/guardian, in case of emergency contact (other than parent):

1. _____ Phone _____

2. _____ Phone _____

Student's Physician _____ Phone _____

Health Insurance _____ Policy Number _____

Hospital Preferred _____

Kutztown Area School District school physician standing orders authorizes district nurses to administer, with your permission, the following medications to students (below):

PLEASE CHECK YES OR NO TO THOSE MEDICATION(S) FOR WHICH YOU GIVE PARENTAL PERMISSION FOR A NURSE TO ADMINISTER TO YOUR CHILD .

ACETAMINOPHEN (Tylenol) Yes No

ANTIBIOTIC OINTMENT Yes No

COUGH DROPS yes No

COUGH suppressant (Robitussin) Yes No

ANTI-ITCH CREAM (Hydrocortisone/Caladryl) Yes No

ANTACID (Tums) Yes No

My child has the following health conditions that the school should be aware of: _____

My child is allergic to: _____ My child wears glasses: Yes No

List all current medications: _____

Has the student had any serious illness or operation in the past year? _____

Does your child have any special health needs, problems, or restrictions? _____

I give the school nurse permission to share information concerning my child's health with appropriate KASD personnel in order to insure my child optimal care and safety. YES _____ NO _____

I authorize Kutztown Area School District personnel to provide first aid services to my child as stated in the standing orders prescribed by the Kutztown Area School District doctor. In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me or in an absolute emergency I hereby authorize the school to disclose any necessary information regarding my child to emergency health care providers and to make whatever arrangements appear necessary for the immediate care of my child.

Parent/Guardian Signature _____ **Date** _____