Homeroom \_\_\_\_\_\_\_\_ Bus# \_\_\_\_\_\_\_ Grade\_\_\_\_\_\_

Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_ M/F\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Lives With (circle one) Both Parents Father Mother Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ **Check if this is new address and phone # in the last year**

Parent Contact Information: \*Please indicate which phone number to contact first\*Do you prefer: Voice call\_\_\_\_\_\_ Text Message\_\_\_\_\_

Father: Name \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Home/Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Father’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Cell#\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ \_\_\_\_\_ Mother’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other persons who will assume responsibility for the care of your child if you cannot be reached **(Required)**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please List other children in the household

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dentist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please Notify School Immediately of Any Changes)**

Does your child have any special health problems or physical limitations that the school nurse or teachers should know about? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization in the last year: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_ Reason for Hospitalization \_\_\_\_\_\_\_\_ \_\_\_ Concussion in the last year: Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

List any medication (with dosage and frequency) that your child takes at home or school:

Inhaler: Yes \_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

Other Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have severe allergies (Latex, Bee, Food or Medication) Yes \_\_\_\_No\_\_\_\_ Is your child prescribed an EPI-PEN? Yes\_ \_\_ (last used \_\_\_\_\_\_\_) No ­­\_\_\_\_\_\_\_\_\_

List all Food and Medication Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Does your child have vision or hearing problems: Yes\_\_\_\_\_\_ No\_\_\_\_\_\_ If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Services Mandated by State Law of Pennsylvania**

Growth and Vision yearly - Hearing: K, 1, 2, 3 7th and 11th - Scoliosis 6th and 7th - Dental Health and Dental Screening

\* I understand that my child will receive the indicated school health screenings as mandated by law of PA unless I submit a written request to the school nurse stating that they are not to be performed on my student.

The Commonwealth of PA REQUIRES that students in grade K, 6, 11 receive physical examinations. You may choose to have the exam done by your own health care provider or the school physician. Please indicate your choice below.

\_\_\_\_\_\_\_I give permission for the school doctor to examine my child free of charge

\_\_\_\_\_\_\_ I will have my child examined by his/her physician at my expense.

I hereby give consent for treatment for minor ailments, emergency care, as deemed necessary by the school nurse, physician or the state. I also give consent and authorize the school nurse to communicate with my child’s physician, authorize release of the immunizations, yearly physicals, and medical records and complete mandated screenings.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*Crawford Central School District Medication Administration Permission\*\*\*\*\*\*\*\*\*\*\***

Please cross out any medications you would **not** like your child to receive during school hours.

**\*\* Ibuprofen (Motrin/Advil) \*\* Acetaminophen (Tylenol) \*\* Benadryl** Allergic Reaction **Visine Antibiotic Ointment**

**Sting relief 1% Hydrocortisone Cream Muscle Rub Cream Orajel/Anbesol Sore Throat Spray Aloe Ungentine (**Burn Cream)

 **Antacid (Tums) Cough Drops (non-medicated) Callergy Lotion**

**First Aid Antiseptic/Pain Reliving Spray** (Bactine)

I consent to the use of these over the counter medications for my child. They will only be administered as needed. Dosing may not exceed the manufacturers’ recommended dose or school physician’s order. I have reviewed the medication and have crossed out any medication that I do not want my child to receive.

Parents/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*SCHOOL PHYSICIAN ORDERS ALLOW FOR ADMINSTRATION OF ANY ABOVE MEDICATION TO NO MORE THAN 4 TIMES A MONTH\*\***