POTTSTOWN SCHOOL DISTRICT - ANNUAL STUDENT INFORMATION UPDATE

Name:	Grade:	Building:	Homeroom:
Address:	Gender:	Birth Date:	Student ID#
Address:		Home Language:	
City/State/Zip:		Home Phone:	

Please verify all Guardian and Emergency Contact Information:

Parents/Guardians and other adults to be contacted and to whom students may be released:

*If there are any **changes** to the Student/Parent/Guardian's address, please provide proof of residency to the building office.

Name/Relationship:	**Please update/make corrections here⬇:**
Address:	
Home Phone:	
Cell Phone:	
Work Phone:	
Auto Call Phone:	
Text Msg. Phone:	
Email:	
Name/Relationship:	
Address:	
Home Phone:	
Cell Phone:	
Work Phone:	
Auto Call Phone:	
Text Msg. Phone:	
Email:	
Name/Relationship:	
Address:	
Home Phone:	
Cell Phone:	
Work Phone:	
Auto Call Phone:	
Text Msg. Phone:	
Email:	

The Pottstown School District wishes to increase our communications with the families of our students.

- If you wish to receive an Auto Call (example: snow day closing), please verify/supply in the **"Auto Call Phone"** above.
- If you wish to receive information from the district by text message, please verify/supply in the **"Text Msg. Phone"** above.
- Please verify/supply an email address above for school communications and also for connection into our **Home Access Center**.

Other children attending Pottstown School District:

Student's Name	Student's ID #	Student's Name	Student's ID #

HEALTH HISTORY
TO BE COMPLETED BY PARENT/GUARDIAN

1. **Check any of the following your child has experienced within the past year.**

___ ADD/ADHD	Date_____	___ Asthma	Date_____
___ Allergies: Food	Date_____	___ Bladder Problems	Date_____
___ Allergies: Insect	Date_____	___ Blood Problems	Date_____
___ Allergies: Medication	Date_____	___ Convulsions	Date_____
___ Allergies: Seasonal	Date_____	___ Epilepsy	Date_____
___ High Fever	Date_____	___ Diabetes	Date_____
___ Eye: Glasses	Date_____	___ Hearing Aid	Date_____
___ Eye: Contacts	Date_____	___ Ear Tubes/Bobbins	Date_____
___ Heart Murmur	Date_____	___ Stomach Ulcer	Date_____
___ Other Heart Problems	Date_____	___ Other Medical Problems	Date_____

If yes to any of the above, please explain_____

_____

_____

2. **List any medications your child is presently taking:**_____

_____

_____

(Please circle)

3. **Is your child presently under the care of a physician or other health care provider?** **YES NO**

4. **Do you have insurance?** **YES NO**

5. **Do you give your consent for the Pottstown School District to share this information in a confidential list to teachers and staff?** **YES NO**

6. **Has there been any change in your family structure?** **YES NO**

7. **I give permission for my child to be examined by the school doctor/dentist as mandated by the state.** **YES NO**

In the event of a nuclear evacuation, the Pottstown School District will no longer administer the Potassium Iodide (KI) tablet. If you wish to have your child receive the KI tablet, then a medication permission slip must be completed by you and your doctor and the medication must be supplied to the school.

If you have health concerns regarding your child, please contact the school nurse.

Signature of Parent/Guardian_____ **Date**_____