POTTSTOWN SCHOOL DISTRICT - ANNUAL STUDENT INFORMATION UPDATE

Name:	Grade:	Building:	Homeroom:
Address:	Gender:	Birth Date:	Student ID#
Address:		Home Language:	
City/State/Zip:		Auto Call 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.**

Please review; update and make any corrections:

#1 Contact Name:	Auto Call Phone	
Address	Cell Phone	
Address	Home Phone	
Email	Work Phone	
	Text Msg Phone	
#2 Contact Name:	Auto Call Phone	
Address	Cell Phone	
Address	Home Phone	
Email	Work Phone	
	Text Msg Phone	
#3 Contact Name:	Auto Call Phone	
Address	Cell Phone	
Address	Home Phone	
Email	Work Phone	
	Text Msg. Phone	
OPTIONAL ADDITIONAL CONTACT		
#4 Contact Name:		
Address	Cell Phone	
Address	Home Phone.	
Email	Work Phone	

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 and Grade	Student's ID #	Student's Name and Grade	Student's ID #

***All Kdg, 1st, 3rd, 6th, 7th, and 11th grade students – MUST COMPLETE!**

The state of Pennsylvania mandates all students entering school, in kindergarten/1st gr, 6th gr, or 11th gr have a physical exam and all students entering school, in kindergarten/1st gr, 3rd gr or 7th gr receive a dental exam.

It is recommended that your family dentist/physician do this examination, as he or she can assist you in any treatments or corrections that may be necessary In addition, your child may be more comfortable in a setting he or she is familiar with An examination performed any time after July 1 2018 is acceptable The private dental/physical form is available on the school website or in the nurse's office Please return the completed private dental/physical form by September 30, 2019 If you prefer to have your child examined by the school dentist/physician, a basic dental or physical examination will be done during the school year

☐yes ☐no I prefer to have my family dentist/physician do the exam and will return the completed form by September 30, 2019
I understand if the form is not received by the school nurse my son/daughter will be scheduled for a school dental/physical exam

☐yes ☐no I prefer to have the school dentist/physician examine my child

☐yes ☐no I wish to attend the physical/dental exam

(Please turn over and complete other side.)

HEALTH HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

CHECK ALL THAT APPLY:	YES	NO	CHECK ALL THAT APPLY:	YES	NO
Arthritis/Rheumatic Disease			Eating Disorder		
Asthma			Emotional Problems		
Requires Inhaler at school (*will need a doctor's order)	*		Family History of Sudden Death		
Attention Deficit Disorder/Hyperactivity			Hearing Loss		
Bleeding Disorder			History of Fainting		
Cancer			Orthopedic Problems		
Cardiovascular Condition/Prolonged QT syndrome			Seizure Disorder		
Cerebral Palsy			Sickle Cell Disease		
Cystic Fibrosis			Spina Bifida		
Diabetes Type I			Tourette's Syndrome		
Diabetes Type II			Vision Concerns		
Digestive Disorders (IBS/GERD/CROHN's)			**MY CHILD WEARS:** (please circle Yes/No) Glasses - YES NO Contact Lens - YES NO Hearing Aides - YES NO		
Is your child presently under the care of a physician?			Do you have insurance?		
Do you give your consent for the PSD to share this information in a confidential list to teachers/staff?			Has your child had a head injury and/or concussion within the last year?		
Has there been any change in your family structure?					

PHYSICIAN _____ PHONE #_____
DENTIST _____ PHONE #_____

I give the school nurse permission to administer the following over-the-counter medications as needed Tylenol, Ibuprofen, Chloraseptic lozenge/ throat spray, Tums, and Benadryl – generic medications may be substituted *Ibuprofen is limited to 2 doses weekly without written physician permission **For life threatening allergic reactions, injectable adrenaline (Epi-Pen) will be administered ** **I GIVE PERMISSION: YES ☐ NO ☐**
*No medications will be given the first or last one and a half hours of school

Is your child **ALLERGIC** to **Bee stings? YES ☐ NO ☐** **INSECT bites? YES ☐ NO ☐** **Latex? YES ☐ NO ☐**
If **YES, describe reaction and treatment:**_____

Is your child **ALLERGIC** to **PEANUTS? YES ☐ NO ☐** **TREE NUTS? YES ☐ NO ☐**
Is your child **ALLERGIC** to any other **FOOD/SUBSTANCE? YES ☐ NO ☐**
If **YES,** please list food and reaction _____

TREATMENT FOR REACTION_____
If **YES,** will your child be eating food served in the cafeteria? **YES ☐ NO ☐**
Is your child able to self-monitor to avoid exposure to their food allergen? **YES ☐ NO ☐**

DOES YOUR CHILD REQUIRE AN EPI-PEN? YES ☐ NO ☐
******If your child requires an Epi-pen for the treatment of a known allergy, it is the parent/guardians responsibility to provide the school nurse with the Epi-pen and physician orders for usage.**

PLEASE COMPLETE THE FOLLOWING SECTION RELATING TO MEDICATIONS YOUR CHILD RECEIVES
Daily or as needed, including medications taken at home If required at school, must have medication order from physician

Medication Name	Time	Reason for Use

ARE THERE ANY OTHER HEALTH CONCERNS THE SCHOOL NURSE SHOULD BE AWARE OF?
_____
_____
_____

In case of an emergency, when parents or emergency contacts cannot be reached, I give permission to school authorities to use their judgment in obtaining care for this student. Any cost incurred will be the responsibility of the parent/guardian **Please provide immunization updates for ALL students **

I have reviewed/completed both sides of this document and agree to update the school nurse with any changes.

Signature of Parent/Guardian_____ **Date**_____

(Please complete both sides of this form.)