Pottstown School District

Annual Student Information Update

Name ______________ Grade __________ Building __________ Homeroom __________

Address ______________ Gender __________ Birthdate __________ SS # __________

______________ Phone __________ Municipality __________ Student # __________

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

Name	Relationship	Phone	Cell	Employer	Work Phone

Other children living at home:

Name	Gender	Birthdate	Grade	School	Student #
		/ /			
		/ /			
		/ /			
		/ /			

Special Health Conditions/Allergies:

____

____

____

____

Family Physician ______________ Phone __________ OK to Contact

Family Dentist ______________ Phone __________ OK to Contact

Preferred Hospital ______________

*** IN EXTREME EMERGENCY IT MAY BE NECESSARY TO TRANSPORT YOUR CHILD TO THE NEAREST HOSPITAL. ***

I give permission to the staff of the above named school district to transport, or make arrangements for the transportation of my child to receive emergency medical care in the event that persons listed above cannot be contacted.

Signature Of Parent/Guardian ______________ Date __________

. 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. **In the event of a nuclear evacuation, I give the Pottstown School District permission to administer the Potassium Iodide (KI) tablet to my child:** _____ **YES** _____ **NO**

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

4. **Has your child seen a dentist in the past year?** **YES** **NO**

   If yes, date______________ **Dentist** ____

5. **Do you have insurance?** _____ **YES** _____ **NO**

   Name of Insurance Co. ____
   Group Number _________________ **Policy Number** _________________

   DPW/MA (Medical Assistance Card) _____ **YES** _____ **NO** **Card Color** _______
   Card/Record No. _____________________ **Line Number** _______________

6. **Has your child received any of the following immunizations in the past year?**

Date_________ Diph & Tet (DTaP,DTP,Td,DT)	Date _________ Polio (IPV or OPV)
Date_________ Hepatitis B	Date _________ Measles, Mumps, Rubella
Date_________ Varicella	Date _________ TB Test
Date_________ Hemophilus Influenza	
Date_________ Tetramune (DPT&HIB)	

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

8. **List medication your child is presently taking.** ____

   ____

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