UPPER ADAMS SCHOOL DISTRICT – STUDENT HEALTH PROFILE

For Office Use Only: Grade: _____ Homeroom: _____
AM Bus _____ PM Bus _____ Transfer Bus (if needed) _____
Registration Date: _____ Entry Date: _____
YOG: _____ Student ID: _____
Proof of Birth: ☐ Birth Certificate ☐ Passport ☐ Other _____

Student's Full Name:	Gender:
Street Address: City/State/Zip:	Date of Birth:
Mailing Address: (Please include P. O. Box)	City/State of Birth:

HEALTH/EMERGENCY INFORMATION

Family Doctor: _____ Doctor Phone: _____

Family Dentist: _____ Dentist Phone: _____

Has your child ever had a serious illness/operation? ☐ Yes ☐ No
If yes, what? _____ When? _____

Is your child currently taking any medication? ☐ Yes ☐ No
If yes, what? _____ What For? _____

Does your child need to take any medication at school? ☐ Yes ☐ No
If yes, what? _____ What For? _____

Has your child ever been diagnosed by a physician with Asthma? ☐ Yes ☐ No
Signs and symptoms of an attack: _____
Will your child require an inhaler at school? ☐ Yes ☐ No

Has your child had an allergic reaction to a specific food, medication, or insect? ☐ Yes ☐ No
If yes, type of allergy? _____
Signs and symptoms of allergy: _____
Treatment needed: _____

* ***IF your child needs a food removed or substituted from a lunch tray, the school must have a signed note from your child's doctor.***

Does your child have any other special health concerns or emotional problems (including hyperactivity) which you or your family physician feel should be known to school authorities? ☐ Yes ☐ No
If yes, please explain: _____
_____

Pennsylvania school health laws require every child of school age be given a physical and dental exam upon original entry into school. New students that transfer to our district, regardless of grade, are required to have a physical and dental exam if there is no Pennsylvania school record available. Please state if you prefer to have the exam completed by your family doctor/dentist or by the school doctor/dental hygienist:

☐ Family Physical ☐ School Physical
☐ Family Dental ☐ School Dental

IMPORTANT: PROOF OF IMMUNIZATION IS REQUIRED TO REGISTER FOR SCHOOL.
Please provide the school with an updated copy of your child's immunization record.
We must receive a copy of this record for your child to start school.

FLUORIDE SUPPLEMENT CONSENT:

The Upper Adams School District, with the endorsement of the PA Department of Health, is offering a valuable health service to your child. With parental permission, children have an opportunity to receive one (1) mg. fluoride tablet each day. The program is offered in grades K-8. The tablets will be given to your child each day by the homeroom teacher. The Fluoride Supplement Program has been recommended by the Dental Consultant for the Upper Adams Hygienist/School Nurse. **This service will be continued in grades K-8 unless your permission is withdrawn.** This project is very important to the oral health of your child. Participation is entirely voluntary and without cost to you. We encourage you to allow your child to participate in this valuable health activity. This preventive program, however, should not take the place of regular dental care by your dentist or proper home care. Please check below to indicate whether you would like your child to participate in this program:

☐ I would like my child to participate in the school fluoride supplement program offered by UASD. I understand that this permission will be valid through Grade 8 unless I notify the school to discontinue dispensing the fluoride tablets.

☐ I would not like my child to participate in the fluoride supplement program offered at school.

☐ My child is currently receiving a fluoride supplement at home and will not participate in the school fluoride program.

The school has permission to give my child the following medications if deemed necessary:

☐ Yes	☐ No	Antacid	☐ Yes	☐ No	Orajel/Anbesol
☐ Yes	☐ No	Benadryl	☐ Yes	☐ No	Antibiotic Ointment
☐ Yes	☐ No	Throat Lozenges/Cough Drops	☐ Yes	☐ No	Anti-Itch Cream/Lotion
☐ Yes	☐ No	Visine Eye Drops	☐ Yes	☐ No	Hydrocortisone 1% Cream/Lotion
☐ Yes	☐ No	Tylenol or Ibuprofen			

EMERGENCY CONTACT INFORMATION

Emergency Contact #1:
Emergency Contact #1 Phone: (H) _____ (W) _____ (C) _____
Relationship to Child:

Emergency Contact #2:
Emergency Contact #2 Phone: (H) _____ (W) _____ (C) _____
Relationship to Child:

Emergency Contact #3:
Emergency Contact #3 Phone: (H) _____ (W) _____ (C) _____
Relationship to Child:

Procedure in case of major illness/accident:

1. Parent will be contacted.
2. If this fails, family doctor will be called.
3. If neither parent nor family doctor can be contacted, the school doctor or any other doctor will be called.

In all cases, the welfare of the pupil will be the first consideration. Any medical expenses incurred shall be the responsibility of the parent. If any parent does not agree with this procedure, he/she should notify the school and submit an alternate plan for the care of his/her child.

If emergency treatment is required, may school authorities use their own judgment in sending the child to the Gettysburg Hospital or doctor most easily accessible providing none of the above listed people can be reached? ☐ Yes ☐ No

I hereby verify that the information set forth above is correct and should be included in my child's school record.

Parent/Guardian Signature: _____ *Date:* _____

(updated: 8/25/2017)