TURKEYFOOT AREA SCHOOL DISTRICT
EMERGENCY CARE INFORMATION

Student's Name:____
Last First Middle Grade

Date of Birth: ____________ Address:________________________________
____

Home/Primary Telephone Number:_____________________________________

Cell phone(s) ____________________ ___________________ email address_____________

Business/Work Telephone Number: _____________________________________

2nd Business/Work Telephone Number:___________________________________

In case of an accident or illness in school and the above cannot be reached, please list individuals you would allow to pick up your child. If additional space is needed, attach a piece of paper to this paper and sign it.

Relative/Neighbor's Name & Number: ___________________________________

Relative/Neighbor's Name & Number: ___________________________________

In case of an emergency which would require a call to a physician or a dentist please list

Family Physician's Name: ___________________________ Telephone # _______________

Family Dentist's Name: _____________________________ Telephone # _______________

List any health issues or other information about your child you feel the school should be aware of such as- vision/ hearing, emotional problems, asthma, seizures, medications, ADHD, physical handicap,
etc.____

Please list ANY allergies (environmental, bee stings, food, or medication, type of reaction that occurs, and medication needed):
____

If your child is severely allergic to anything-**you must bring specific instructions from a doctor and the necessary medication (Epi- Pen or Benadryl). Allergy/medication forms can be obtained in nurse's office.**

If an **extreme** emergency would arise-and if a choice is possible, which hospital would you prefer for your child? ____

I DO ________ I DO NOT ________ authorize the Turkeyfoot Valley Area School District to give first aid, if necessary, during the school day. I hereby authorize the school to transport, or to make arrangements for the transportation of my child for emergency care after proper notification to parents or contact above has been made. Parent / guardian assumes complete responsibility if consent is not given.

_________________________________ __________

Signature of Parent/Guardian **Date** **TURN OVER**

PERMISSION FOR MEDICATION ADMINISTRATION DURING SCHOOL

The Pennsylvania Department of Health has mandated rules and regulations for the administration of first aid and medication administration. The Turkeyfoot Valley Area School District procedures involve the use of any "over the counter" medications/treatments listed below approved by the school physician . ****Note: If you wish your child take preferred over the counter medication, please bring the medication to the nurse in the original bottle. Prescription medication must be in a prescription labeled bottle. Medication permission slips can be obtained from the nurse. If your child has asthma or any severe allergies, it is your responsibility to notify the nurse and provide the inhaler or epi-pen if necessary for use at school each year with the appropriate form(s).**

Circle **yes/no** below for your child to receive any of these medications, should the need arise, please sign the form and return it to the school nurse as soon as possible.

YES	**NO**	Tylenol, Acetaminophen, non- aspirin for fever or pain- dose will be age/weight appropriate
YES	**NO**	Ibuprofen for fever, pain- dose will be age/weight appropriate.
YES	**NO**	Tums- for upset stomach.
YES	**NO**	Bacitracin for small wounds after they have been cleaned.
YES	**NO**	Cough drops or chloraseptic spray for sore throat and cough unrelated to a more serious illness.
YES	**NO**	Anbesol gel for toothaches
YES	**NO**	Topical Hydrocortisone cream or Calamine lotion for insect bites, non-serious rashes, or itching
YES	**NO**	Blistex or other ointment for chapped lips
YES	**NO**	Contact solution for contact lenses. Eye drops/ irrigation wash for eye irritations.
YES	**NO**	Topical Sting Relief for bee stings. Benadryl Liquid or pills for localized reaction.
YES	**NO**	Aloe Vera gel for minor burns
YES	**NO**	Epi- Pens for anaphylactic reactions.

I give my consent for the above medications and treatments to be rendered to my child as his/ her condition warrants under the supervision of the School Nurse, or trained Designee. I understand that the school or staff can, in no way, be held responsible for any condition resulting from such medications & treatments. I understand that my child will only be able to receive these medications subject to the availability of the school nurse. Also, I understand that if my child uses the above items in excess, I will be asked to supply the medication from home.

Parent/Guardian Signature Date

TURKEYFOOT VALLEY HEALTH HISTORY

Student's Name ____**Grade**___________

Check the following illnesses/injuries the child has had and list the date if know:

____Measles or 9 day Measles
____ Mumps
____ Whooping Cough
____ Rheumatic Fever
____ Fractures(list) ________________
____
____ German or 3 day Measles
____ Chickenpox
____ Pneumonia
____ Other (list)
____
_____ Concussions

Please circle type of medical insurance: ACCESS__________ CHIP PRIVATE___________ NONE
Daily medication at home? ( ) yes or no ( ) At school? ( ) yes or no ( )
Explain: Medication name/dosage/ frequency____
List serious illness, surgeries, hospitalizations, or injuries___________________________________
____

Is your child currently under the care of a physician or clinic now? Yes No
If yes, please explain ____
____

Does your child have any of the following health concerns:

a.) trouble with eyes or seeing Yes No
b.) wears glasses or contact lenses Yes No
c.) trouble with ears or hearing Yes No
d.) wears hearing aids Yes No
e.) trouble with allergies (seasonal, bee stings, contact, food, medications) Yes No
f.) asthma Yes No
g.) speech Yes No
h.) frequent headaches Yes No
i.) seizures Yes No
j.) thyroid Yes No
k.) heart murmur/condition Yes No
l.) ADD or ADHD Yes No
m.) skin problems Yes No
n.) frequent nosebleeds Yes No
o.) special diet Yes No
p.) difficulty sleeping Yes No
q.) problems/concerns with general growth and development Yes No
r.) twitching Yes No
s.) bed wetting or soiling underpants Yes No

If you answered yes to any of the above, please explain in detail any reaction and treatment necessary
____
____

Does your child require an epi-pen for any of the allergies indicated above? Yes No
Does your child need a special diet for a food allergy or other health related need ? Yes No

If yes, a special diet form will need to be completed by your child's doctor to make the necessary substitutions in the cafeteria. This is a one-time form and can be obtained from the cafeteria manager or the nurse's office. Please complete it within the first week of school if not before.

Would you like to set up a meeting with the nurse to discuss any health concerns for your child? Yes No

Sodium Fluoride tablets are given to students in **grades K4-6 only** for dental health reasons.
____ Please give the fluoride tablets in school.
____ DO NOT give the fluoride tablets in school.
____ My child takes the tablets at home.

**** Fluoride will be given in school until written notification to discontinue it is provided.**

Parent/Guardian Signature:______________________ Date__________

The Pennsylvania Department of Health requires students in Kindergarten 4 (if attending) or Kindergarten 5, 6th grade, and 11th grade or new out of state entry to have a physical examination and students in Kindergarten, 3rd, and 7th or new entry to have a dental exam. We recommend that these examinations be done by your family physician and family dentist since he or she can best evaluate your child's health and assist you in obtaining necessary treatment and being up-to-date on immunization requirements. You must have the exams done by either your own doctors or the school's.

If you want your family doctors to do the exams please note this below and the proper exam forms will be provided to you.

The school will provide a free medical examination if you prefer. A Physician's Assistant from Somerset Family Practice will perform this exam. The examination includes the taking of a health history and a physical exam. The physical exam is very general-the heart, lungs, skin, eyes, ears, nose throat, abdomen, neuromuscular system and general nutrition are addressed. A genital/hernia exam will be done on the boys – the Physician's Assistant is female so if this will cause a problem please have the physical done at your family doctors.

If you choose to have the physical exam done at the school, please complete the first page of the attached physical form for health history for the exam provider and return it to school nurse. You will be notified of the date and time.

PHYSICAL EXAM
____ I want the exam done by my family physician
____ I want the exam done at the school
____ I want to be present during the exam

DENTAL EXAM
____ I want the exam done by my family dentist
____ I want the exam done at the school
____ I want to be present during the exam

Student Name:___________________________

Parent/Guardian Signature:_______________________ Date: ________

*** These exams must be completed no more than six months prior to start of school. Private physician exams must be returned to the school by December 31st if possible.

TURKEYFOOT VALLEY AREA SCHOOL DISTRICT
PERMISSION TO SHARE HEALTH INFORMATION

Student Name: ____

Date of Birth: _______________________

I, __________________________, give permission to the Turkeyfoot Valley School District to communicate either verbally or in writing any medical condition (including lists of students/athletes) shared by me or as a result of an examination. Examinations would include: athletic physical examination, mandated physical examinations, dental examinations an immunization records.

This information may be communicated to the following personnel: (Please cross out any you wish to exclude)

School administrators
Athletic directors
Athletic trainer's
Coach's
Teachers/substitute teacher's
Cafeteria Staff (i.e. food allergy)
Teacher's aides
Bus Drivers (i.e allergies to foods, bee stings, or seizures)
nurse/substitute nurse
school/team physicians
health services/school dentist
family doctor/dentist
counselors
secretaries

Please understand that the information is used by school employees only to provide for the health, safety, and well-being of the student.

This consent is valid for the duration of enrollment for the above mentioned student, unless revoked by written notification, in the interim.

I acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. ALL information will be handled confidentially in compliance with the Federal Privacy Act.

____
Signature of Parent or Guardian

____
Date of Authorization

TURKEYFOOT VALLEY AREA SCHOOL DISTRICT

TO: Parents of Students Attending Turkeyfoot Valley Area School District

FROM: Rebekah Marietta, BSN, CSN

RE: Health Insurance Portability and Accountability Act-Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996. Recently changes have been made to include school districts in the compliance requirements. Turkeyfoot Valley Area School District has a policy manual setting forth its written policies and procedures to follow HIPAA. By law, the District is required to distribute a Notice of Privacy Practices to all students. We are also required to obtain a written acknowledgement from the student/parent (s) of his or her receipt of the Notice of Privacy Practices. Below is an acknowledgement form that needs to be signed by the student and parent. Your signatures acknowledge that you have received the notice. It does not authorize the District to disclose protected health information concerning the student. You must obtain an authorization form from the District if you wish to have protected health information about your child disclosed.

TURKEYFOOT VALLEY AREA SCHOOL DISTRICT
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the NOTICE OF PRIVACY PRACTICES. I understand that I should read the notice in order to determine how medical information about my child may be used and disclosed and how I can get access to this information.

Student Signature: ____

Parent/Guardian Signature:
____

Date: ______________________________

TURKEYFOOT VALLEY AREA SCHOOL DISTRICT
REGISTRATION RECORD

__________________ ____________________ _____________________
LAST NAME FIRST MIDDLE

Date Of Birth: ___/___/____ SEX _____ Nickname:___________

Address: ____
____

Home Telephone Number: ___________________
Work Telephone Number: #1___________________ #2____________________

Race: ___American Indian or Alaska Native
___Black, not of Hispanic Origin
___White, not of Hispanic Origin
___Asian or Pacific Islander
___Hispanic

Proof Of Birth: __Birth Certificate
__Baptismal Cert.
__ Hospital Form
__ Other________
Birth Certificate # ___________

Who has legal custody of this child? ____
With whom does this child live?____

	LAST	FIRST
Biological Father:	___________________	__________________
Biological Mother:	___________________	__________________
Step-Father:	___________________	__________________
Step-Mother:	___________________	__________________
Guardian:	___________________	__________________
Foster Parents:	___________________	__________________

** You will need to bring the Birth Certificate and Immunization Records (baby shots-updated and/or complete) in order to register. Your physician's office may also fax immunization records to the school nurse prior to or within 10 day after registration day at (814) 395-3366 or (814) 395- 3232 att: School Nurse. Your child will not be officially registered until proof of AT LEAST ONE DOSE of each immunization can be provided. Please see the immunization requirement paper for complete list of required immunizations. If you have any questions, please contact the school nurse.