SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

CONSENT FOR RELEASE OF INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize the school nurse to communicate as needed with:

Agency/Doctor _____

Address _____

City, State, Zip _____

Telephone _____ Fax # _____

and _____ to communicate with the school nurse and to
(Agency)

release copies of _____ concerning
(Information Requested)

Student _____ Date of Birth _____

Address _____ Zip _____

Name of Parent/Guardian _____

PLEASE MAIL or FAX REQUESTED INFORMATION TO:

School Nurse _____ Phone _____

School _____

Address _____

City, State, Zip _____

Telephone _____ Fax # _____

I understand that the information provided will be used to evaluate the health status of this student on an individual basis and to help in providing a program of health and educational management.

I understand that this authorization will remain in effect from the date hereof to the end of the current school year unless sooner revoked by me at any time in writing.

_____
Signature of Parent/Guardian/Student (if emancipated)

_____
Date signed

THE SCHOOL DISTRICT OF PHILADELPHIA

STUDENT MEDICAL HISTORY

Name of Student	Date of Birth	Date
Name of School	**Room/Book/Section**	**Grade**

Dear Parent/Guardian:

Pennsylvania law requires that all children must have a complete checkup when entering school for the first time and again in middle and high school.

The school nurse can help you with information regarding health insurance. There are free and low-cost insurance plans for which your family may qualify. Please take the attached form to your doctor or clinic when you take your child for this checkup and return the completed form to the school nurse by_____

School Nurse: _____

STUDENT'S MEDICAL HISTORY - TO BE COMPLETED BY PARENT/GUARDIAN

1. Do you have health insurance? ____ Yes ____ No What is the name of your insurance?_____
2. Where do you take your child for checkups?_____ Phone:_____ Fax:_____
3. Date of child's last physical examination?_____
4. Where do you take your child for dental care? _____ Phone:_____ Fax:_____
5. Date of child's last dental examination?_____
6. Does your child take any medicine now? ____ Yes ____ No, If yes, list below:
   - Medicine: _____ How often_____ For what_____
   - Medicine: _____ How often_____ For what_____
   - Medicine: _____ How often_____ For what_____
7. Is your child allergic to anything? ____ Yes ____ No, If yes, to what_____
8. Does your child have any activity restrictions? ____ Yes ____ No, If yes, explain_____

PLEASE CHECK ANY PROBLEM YOUR CHILD HAS/HAS HAD

___ Asthma	___ Dental	___ High Blood Pressure	___ Physical Disability
___ Anemia	___ Diabetes	___ Hospitalized (Surgery)	___ Premature Birth (Under 5 Lbs)
___ Arthritis	___ Drug/Alcohol	___ Learning Problem	___ Seizures
___ Behavior/Emotional	___ Eczema	___ Lung Disease	___ Speech Difficulty
___ Blood Disorders	___ Frequent Colds	___ Lead Poisoning	___ Tuberculosis
___ Cancer	___ Hearing Difficulty	___ Meningitis	___ Vision Problems
___ Chicken Pox at age____	___ Heart	___ Muscle/Bone/Joint	___ Urinating/Kidney Problem

*Additional comments:*_____

_____

_____

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

STUDENT HEALTH STATUS

LAST NAME	FIRST NAME		BIRTH DATE
SCHOOL NAME	ROOM/BOOK	GRADE	DATE OF ISSUE

Please complete this form and return it to your school nurse immediately for the safe care of your child.

To Parent/Guardian:

Your child's health record/history indicates that he/she has been under care for the following health problem(s):

_____

1. Does the student's health problem(s) still exist? _____
2. Does he/she have other health problems? Yes ☐ No ☐ If yes, what are they? _____
   _____
3. Does he/she take medicine?
   Yes ☐ No ☐
   If yes, please give name of medicine, dosage, and time(s).

Medicine	Dosage	Time

4. Does he/she regularly receive treatment/therapy or undergo any testing procedures? _____
   If yes, please indicate kind and how often taken _____
   _____
5. Name of doctor, clinic or health center providing care for the student _____
   Address _____
   Phone # _____ Fax # _____ Date of last visit _____
6. Insurance Provider _____

CONTACTS:

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell/Pager: _____

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell/Pager: _____

Emergency Contact #1: _____ Phone # : _____

Emergency Contact #2: _____ Phone # : _____

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian _____ Date _____

TO SCHOOL STAFF: SEE REVERSE SIDE FOR EMERGENCY CARE

SCHOOL NURSE	PHONE #

S-865 (Rev. 4/06) COMM. CODE 61602445860