Brandywine Heights Area School District
Parent Consent

The laws of Pennsylvania provide for periodic health and dental examinations of school children. Physical exams are to be completed in Kindergarten, Sixth and Eleventh grades. Dental exams are to be completed in Kindergarten, Third, and Seventh grades. Complying with the School Health Act, I wish my child____________________________________ to be examined throughout his/her enrollment at Brandywine Heights by (Check one for each type exam):

1. Physical Exams: _____School _____Private   2. Dental Exams: _____School _____Private

If you choose school exams, you will be notified of the date and time of the exam. Parents are invited to be present. If you choose private exams, the forms are due to the school nurse by September 15th. Please notify your child's school nurse in writing if your child's appointment is after September 15th.

Medical History

Check if your child has had any of the following. If further explanation is needed, please provide on the reverse side of this sheet.

___Allergies(list below*)
___Asthma
___Bronchitis
___Bed Wetting
___Chicken Pox
___Diabetes
___Diphtheria
___Epilepsy
___Hernia
___Intestinal Worms
___German Measles
___Measles
___Mumps
___Nervousness /Irritability
___Pleurisy
___Pneumonia
___Rheumatic Fever
___Rheumatism
___Scarlet Fever
___Seizures/Convulsions
___Tonsillitis
___Thumb Sucking

Special Health Problems

Unusual conditions during pregnancy____.
Type of delivery__________________________________ Baby's Birth Weight_________________.
Unusual circumstances at birth____.
Vision: Eye Injuries _____Yes _____No Glasses Prescribed _____Yes _____No
Hearing: Three or more middle ear infections by 18 months _____Yes _____No
Ear Operations _____Yes _____No; If yes, what and when?_______________________________
____

Fears (such as thunder, strangers, etc.) ____
Surgery (note kind and date) ____
Serious Accidents ____
History of any other illnesses ____
*Is your child allergic to Bee Stings? _____Yes _____No If your child is allergic to Bee Stings, do you plan to provide the school with emergency medication prescribed by your child's doctor? _____Yes _____No
*Food Allergies: ____
*Medication Allergies: ____
*Other Allergies: ____

Please contact your child's school nurse to set up a treatment plan if your child has an allergy or medical condition requiring care during the school day.

Is your child at present under medical treatment? _____Yes _____No
If yes, for what problem? ____
Is your child currently on medication? _____Yes _____No If yes, what medication? ______________________
Please list any medical problems that you or your family physician feel should be known to school personnel. ________________
____
____
Are you receiving DPW or Medical Assistance at present? _____Yes _____No

I Understand the Following:

- That the information I give to the School Nurse is important for the school staff to understand and support the health and education of my child.
- That the information will be kept confidential by the school health staff and may be shared with other professionals in the school only when it is required as part of a comprehensive evaluation and in the best interest of my child's health and education.
- That my written permission is required to share this health record with any other institutions or agencies.

Parent/Guardian Signature_________________________________ Date____________________ Grade__________