



MIDLAND INNOVATION + TECHNOLOGY CHARTER SCHOOL

Annual Health Form

Student _____ DOB _____ Grade _____ School Year _____
(Last) (First) (Middle Initial)

Home Address _____ Student cell phone # _____

School District of residence _____ Last school attended (if new student) _____

Student lives with Mother Father Step-parent Grandparent Other: _____

Mother's Name _____ Home # _____ Cell # _____

Mother's Employment _____ Phone# _____

Father's Name _____ Home # _____ Cell # _____

Father's Employment _____ Phone# _____

Names and grades of brothers and sisters _____

Email 1 _____ Email 2 _____

Family Physician _____ Phone _____

Please list Parent Substitutes who can be contacted regarding student's care in the event a parent cannot be located.
PLEASE NOTE: Only those listed below will be permitted to pick up your child in case of illness or emergency, unless specified by parent/guardian. As per district policy, photo ID may be required.

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

List anyone who is **NOT PERMITTED** to pick up your child from school:

Name _____ Name _____

Agree Disagree This is to certify that, I parent or guardian of the named student, hereby grant permission for the adult supervisors to obtain medical care from any licensed physician, hospital or medical clinic for the student named herein at such time as either parent or guardian cannot be contacted in person or by phone. This authorization shall also include all activities, and we do hereby waive, release, absolve, indemnify, and agree to hold activity sponsors, organizers, supervisors, and participants, for any claim arising out of injury to the student or accidents that may occur during the activity.

Agree Disagree Any student requiring emergency care will be transported via ambulance to the nearest hospital. If school representatives are unable to contact parent/guardian in the event of an emergency, the school will have the student transported by ambulance service to the nearest hospital.

Agree Disagree I give my permission for the school nurse to contact my child's physician for any medical concerns.

Agree Disagree I give permission for my child's health information to be shared with school staff and emergency personnel on a need to know basis.

PLEASE COMPLETE HEALTH INFORMATION



Health Information

ALERT TO PARENTS/GUARDIANS: If your child has a serious medical condition, **it is vital that you discuss this with the School Nurse immediately.** The school **must** know of **LIFE THREATENING** conditions (for example allergy with anaphylaxis, diabetes, asthma or seizures) **prior** to the start of school. **All** necessary paperwork (physician order and parental consent form) **must** be on file for any medication necessary to treat the student prior to or on the day of the student’s arrival.

Asthma requiring an inhaler Yes No **Severe Allergy** requiring Epi-Pen Yes No **Allergy**

_____ **Diabetes** Yes No Uses a pump Yes No **Seizure**

Disorder Yes No Takes medication Yes No Date of last seizure _____

ADHD Yes No Yes No Medication: _____

Non-life threatening allergy Yes No Food _____ Medicine _____ Other _____

Specify reaction to mild allergy or allergen: Rash Swelling Hives Vomiting Local reaction Other

Recent concussion: Yes No Date _____ Seen by health care provider Yes No

Recent surgery and/or hospitalization: Yes No Date _____ Explain _____

Please note any other health concerns/conditions _____

MEDICATION

Please mark which OTC medications you permit the nurse to give your student as needed. MITCS has “standing orders” written by the school physician for these medications (**with a limit**) that can be given.

Acetaminophen Yes No **Ibuprofen** Yes No **Antibiotic ointment** Yes No **TUMS** Yes No

Anbesol/Oragel Yes No **Sting/burn gel** Yes No **Benadryl** Yes No (severe allergic reaction only)

The following screenings are mandated by Pennsylvania School Code. Please notify the school nurse annually in writing or by email if you do **not** wish to have the screenings done at school.

Vision: All grades **Hearing:** Grade 11 and all special ed students **Ht/Wt:** All grades

Yes No Does your child have medical health insurance?

Health Insurance Provider _____ Policy Number _____

Yes No In the event of a radioactive emergency, do you want your child to receive **potassium iodide** if instructed by public health officials? (Information page provided in Student Handbook)

Parent/Guardian Name (printed) _____ Relation _____

Signature _____ Date _____