



Barley Mill Plaza - Building #26
4403 Lancaster Pike
Wilmington, DE 19805

Phone: (302) 351-8200
Fax: (302) 233-7376

STUDENT'S NAME: Last Name _____ First Name _____ M.I. _____

Birthdate: _____ Grade & Homeroom Teacher: _____ Bus #: _____

Guardian #1 - Name & Address: _____

Guardian's Cell #: _____ Work #: _____ Home #: _____

Guardian's Email: _____ Relationship to Student: _____

Employer: _____ Occupation: _____

Guardian #2 - Name & Address: _____

Guardian's Cell #: _____ Work #: _____ Home #: _____

Guardian's Email: _____ Relationship to student: _____

Employer: _____ Occupation: _____

If Parent(s)/Guardian (s) cannot be reached, call the following Emergency Contacts:

1. Name/ Phone Number(s)/ Relationship to Student _____
2. Name/ Phone Number(s)/ Relationship to Student _____
3. Name/ Phone Number(s)/ Relationship to Student _____

Family Physician Name & Phone #: _____

Family Dentist Name & Phone #: _____

Medical Insurance Information: _____

I give permission for the nurse to administer the following medications to my child as needed:

***** (Please mark each medication that you authorize the nurse to give) *****

_____ Ibuprofen (Advil / Motrin) _____ Benadryl _____ Tums _____ Antibiotic Ointment/Spray

_____ Acetaminophen (Tylenol) _____ Ambesol _____ Cough Drops _____ Throat Spray

Parent/Guardian Signature: _____ Date: _____

STUDENT HEALTH HISTORY UPDATE

This information will be shared on a need-to-know basis with staff, administration and emergency medical staff in the case of an emergency unless you notify us otherwise. This form is kept in the Nurse's Office.

STUDENT'S NAME:

Last Name

First Name

M.I.

Birthdate:

Parent/Guardian Signature:

Date:

PLEASE MARK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING AND PROVIDE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS SECTION:

1. ADD/ADHD Bleeding Emotional Physical Disability
 Allergies to FOOD Bone/Spine Hearing Seizures
 Allergies to NON-FOOD Bowel/Bladder Heart Speech
 Asthma Chicken Pox Infections Surgery
 Behavior Diabetes/Endocrine Kidney Vision
 OTHER (specify): _____

COMMENTS/ADDITIONAL INFO:

2. Does your child have ANY allergies? YES (Please complete this question) NO (Skip to #3)
 Food (specify): _____

What Happens? _____

Medicine (specify): _____

What Happens? _____

Insects/Animals/Environment (specify): _____

What Happens? _____

Latex/Adhesive (specify): _____

What Happens? _____

3. Is your child being treated or evaluated for any health conditions?
 NO YES (Specify): _____

Is your child on any medication or treatment?
 NO YES (Name of medicine): _____

Does your child need medicine during school hours?
 NO YES ***IF YES, CONTACT SCHOOL NURSE TO MAKE ARRANGEMENTS***

Does your child have an Epi-pen or an Inhaler?
 NO YES ***IF YES, CONTACT SCHOOL NURSE FOR FURTHER INFORMATION***

5. Has your child had any recent (over the past 1 year) emotional upsets (death, separation/divorce, move)?

NO YES Specify: _____

6. Date of child's last:

Physical Exam: _____ (Please provide a copy to the Nurse)

Dental Exam: _____ Does child wear braces? NO YES