Washington New Church School CONTACT form and Health Information

2021-2022 School Year

CHILD'S NAME:		MOTHER'S/GUARDIAN NAME:	
		HOME PHONE:	
DATE OF BIRTH:		WORK PHONE:	
AGE:		CELL PHONE:	
GRADE		Email:	
MEDICAL CONDITIONS:		FATHER'S/GUARDIAN NAME:	
		HOME PHONE:	
ALLERGIES:		WORK PHONE:	
		CELL PHONE:	
		Email:	
CURRENT MEDICATIONS:		ALTERNATE CONTACT'S NAME:	
		HOME PHONE:	
FAMILY DOCTOR:		WORK PHONE:	
DOCTOR'S PHONE:		CELL PHONE:	

IN CASE OF AN EMERGENCY

In a medical emergency, which hospital do you wish your child to be taken to - Nearest? Arundel Medical Center? Prince George's Hospital? Doctors' Hospital? Holy Cross Hospital? Children's National Medical Center? Bowie Health Center? or other (please specify):

- Confidential -

1. Does your child have any health condition, disability, or any other relevant health issue or concerns which may affect his/her safety in the school environment, the safety of others in the school environment, or his/her ability to learn and grow in our school environment. (Conditions may include, but are not limited to: Allergies, diabetes, asthma, physical handicap, disabilities, ADD/ADHD, etc. that may require emergeny services.)

YES _____ NO _____

If YES please describe condition(s): _____

PLEASE NOTE: It is important to answer the following question (#2) even if the medication is given at home only so that in the event of an emergency, we are able to inform emergency personnel of all current medication your child is taking.

2. Is your child taking any medication prescribed by a doctor or any other health professional?

YES _____ NO _____

If YES please list medication(s):

For ANY medication to be administered at school, please see request Pysicians Medicine Order Form (PMOF) from the office.

3. Does your child have any **eye health** concerns which may affect his/her safety in the school environment, the safety of other students in the school environment, or his/her ability to learn and grow in our school environment?

YES _____ NO _____

If YES please describe condition(s):

Does your child wear glasses or contacts?

YES _____ NO _____

4. Does your child have any **ear or hearing problems** which may affect his/her safety in the school environment, the safety of other students in the school environment, or his/her ability to learn and grow in our school environment?

YES _____ NO _____

If YES please describe condition(s):

Does your child wear a hearing aid?

YES _____ NO _____

5. Do you have any concerns about your child's behavior or emotional well being which may affect his/her safety in the school environment, the safety of other students in the school environment, or his/her ability to learn and grow in our school environment?

YES _____ NO _____

If YES please give details:

6. Should there be any **restriction of physical activity** in school or especially on the playground or in Physical Education?

YES _____ NO _____

If YES, please explain the nature and duration of the restriction, **verified with a note from your doctor:**

7. Is there medication that your child takes that is to be administered at school either prescription (inhaler, antibiotics, epi-pen, topical ointments etc.) or over the counter (OTC) such as medication for pain (Tylenol or Ibuprofen)?

YES _____ NO _____

If YES, please explain and **request a Pysicians Medical Order Form (PMOF) from the office** - which is required for adiminstraton of all medications whether prescription or over the counter (OTC):

8. Periodically the school and classrooms have parties and birthdays that involve treats and food. Please explain any dietary allergies and/or restrictions your child might have that we should be aware of (for example: nut, dairy or wheat allergies).

YES _____ NO _____

If YES, please explain:

PARENT/GUARDIAN SIGNATURE: _____

DATE:

It is a Maryland State Law that current immunization records are kept on file at the school. Please enclose a copy of your child's Immunization record with this inventory.