Washington New Church School
Health Inventory/Emergency Contact Information

Student Information

Name: _____

DOB: _____ Grade: _____

Student lives with: ☐ Both Parents ☐ Mother ☐ Father

Parent Information

Mother/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Father/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Alternate Contact (in case of an emergency)

Name: _____ Relationship to Student _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Local Alternative Home

Please provide the name and phone numbers of a person who lives within easy walking distance from the school where we can take your child(ren) in the event that we have to evacuate and cannot reach you. (If you have no one nearby we can assign you someone in our neighborhood)

☐ I request to be assigned a local home

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

In Case of 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):

Hospital: _____

Health Care Providers

Physician or Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Optometrist/ Ophthalmologist: _____

Phone: _____ Email: _____

Dentist/ Orthodontist: _____

Phone: _____ Email: _____

Health Inventory Questionnaire

1. Does your child have any health condition, disability, or any other relevant health issue or concern 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, that may require emergency services, ADD/ADHD, etc.)? ☐ 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 medications 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 P. 3 for Medication administration policies

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 give details:

Date of last exam: _____ *Does your child wear glasses or contacts?* ☐ Yes ☐ No

If Yes, explain:

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 give details:

Date of last exam: _____ *Does your child wear a hearing aid?* ☐ Yes ☐ No

If Yes, explain:

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, read WNCS Medication Policies below, complete the necessary forms (attached) and provide said medication:

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.

Administration of Medication - prescription and over the counter [OTC] - policies

The Washington New Church School must comply with Maryland State law which states "All persons other than registered nurses (RNs) or licensed practical nurses (LPNs) who administer medication in schools… do so under supervision of the RN." What this means is that any medication - prescription ***as well as over the counter medicine*** *may only be administered at the school by a certified medical technician accompanied by* ***both*** *a completed "Medication Prescriber/Parent Authorization Form" (attachment A) and the prescribed or OTC medication in a bottle with the child's name on it.*

The secretary - Bonnie Cowley has been certified as a Medication Administration Technician and is under the supervision of a local RN. If you wish to have the school administer medication prescription as well as over the counter medication please have your physician fill out the attached form and return it to the school along with the medication with your child's name on it.

WNCS HI/ECI Ver2 July 2016