FOR STUDENTS WITH CHRONIC HEALTH CONDITIONS EG: ASTHMA

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

STUDENT HEALTH STATUS

LAST NAME	FIRST NAME		BIRTH DATE
SCHOOL NAME	**ROOM/BOOK**	**GRADE**	**DATE OF ISSUE**

Please complete this form and return it to your school nurse immediately for the safe care of your child.

To Parent/Guardian:

Your child's health record/history indicates that he/she has been under care for the following health problem(s):

_____

1. Does the student's health problem(s) still exist? _____
2. Does he/she have other health problems? Yes ☐ No ☐ If yes, what are they? _____

   _____
3. Does he/she take medicine?
   Yes ☐ No ☐
   If yes, please give name of medicine, dosage, and time(s).

Medicine	Dosage	Time

4. Does he/she regularly receive treatment/therapy or undergo any testing procedures? _____
   If yes, please indicate kind and how often taken _____

   _____
5. Name of doctor, clinic or health center providing care for the student _____
   Address _____
   Phone # _____ Fax # _____ Date of last visit _____
6. Insurance Provider _____

CONTACTS:

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell/Pager: _____

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____ Cell/Pager: _____

Emergency Contact #1: _____ Phone # : _____

Emergency Contact #2: _____ Phone # : _____

I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian _____ Date _____

TO SCHOOL STAFF: SEE REVERSE SIDE FOR EMERGENCY CARE

SCHOOL NURSE	PHONE #