ACADEMIA ANTONIA ALONSO CHARTER SCHOOL

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:_____ Birthdate:_____
Last Name First Name M.I.

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): _____

4. 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 1year) 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

Eye Exam: _____ Does child wear glasses? [ ]NO [ ]YES