

Northern York County School District  
Medical Verification Form

Dear Parent/Guardian

It is very important that we maintain current health records for your child. If you have not yet completed the Medical Verification form on the Sapphire Parent Portal; please see the instructions for *Creating a Parent Account*. If you are still unable to complete the form on line; please complete this paper version and return it to school nurse as soon as possible.

Child's Name: \_\_\_\_\_ Grade \_\_\_\_\_ School: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Please circle any of the Medical Standing Orders you **DO NOT WANT GIVEN TO YOUR CHILD** by the school nurse.

**Bacitracin**    **Ibuprofen**                      **Benadryl**                      **Caladryl (anti-itch lotion) -**                      **Cough Drops (Generic)**  
**Topical Skin Anesthetic (Bee Sting wipe)**                      **Tums**                      **Tylenol (Acetaminophen)**

Please list any Allergies your child has: \_\_\_\_\_

Please List any Medical Conditions your child has: \_\_\_\_\_

List Prescribed medications to be give at school – Name, Dose, and Time ( All medications to be given at school, both prescription and over the counter, **require a written order from your doctor requesting it be given by the school nurse.**

Please List any medications your child takes at Home: \_\_\_\_\_

Please List the name and date of any immunizations your child received in the last year, Name and Date

List any serious health problems/injuries your child has had in the last year and care they are currently receiving from a physician: \_\_\_\_\_

If your child is in Grade 1 – 5 do you want them to receive Fluoride at School: **YES or NO** (Information posted on the website, please call your child's school nurse)

I give consent for NYCSD to release medical information to medical and school personnel in order to promote the health and safety of my child. **YES or NO**

**I understand that Emergency Room transport and treatment, if needed will be at my expense.**

\_\_\_\_\_  
Parent's Signature/ Date