Beth Tfiloh Dahan Community School

HEALTH INFORMATION

Attached is the Beth Tfiloh Health Questionnaire requesting information concerning your child's medical, social and emotional history. This information, though sensitive, will enable us to understand and better care for you child throughout the school day. We encourage you to share as much information as possible, including all medications taken at home prior to school. **ALL OF THE INFORMATION ON THESE FORMS WILL BE KEPT IN STRICT CONFIDENCE.**

Guidelines used for giving proper health care to your child are based on policies of the Baltimore County Health Department and are as follows:

1. A child with a temperature of 100.0 degrees or above is not permitted to be in school. The child must have a normal temperature for **24 hours** (**without Tylenol or Motrin/Advil**) before returning to school.

2. Any child with a communicable disease is not permitted in school. However, **head lice** is addressed individually by the school nurse. Once it is determined by the nurse that the family is treating their case thoroughly, the child will be permitted to attend school, with their hair covered and/or pulled back. The nurse will monitor the student until they are completely free of nits.

3. The following non-prescription medications will be available in an effort to relieve minor discomforts which impede student learning and prevent full participation in classroom activities: Acetaminophen (Tylenol), Ibuprofen (Motrin or Advil), anti-itch ointment, hydrocortisone, bacitracin, Tums, sunscreen and Benadryl for allergic reactions only.
   A CONSENT FORM MUST BE COMPLETED AND SIGNED BEFORE ANY MEDICATIONS WILL BE ADMINISTERED!! (See the Beth Tfiloh Health Questionnaire.)

4. All medications to be administered at school, **PRESCRIPTION** and **OVER-THE-COUNTER,** MUST be **accompanied by a written order** from your health care provider. A parent must bring the medication to school in the **original container.** The order and medication must include name, date, dosage, instructions and doctor's name. If your child starts a new medication, or the current dosage is adjusted, please notify the school immediately.
   NO STUDENT WILL BE ALLOWED TO CARRY AND SELF-ADMINISTER MEDICATION. Please notify the nurse of special circumstances authorized by a physician.

5. Immunizations must be current prior to attending school. Note: All kindergarteners must have had 5 DPT, 4 polio, 2 MMR, and 3 hepatitis B vaccines. Documentation of varicella (chicken pox) vaccination or history of the disease must be included. **Students new** to the school or those **entering Preschool, Gan Aleph, Kindergarten, 5th grade and 9th grade** will need a Baltimore County Health Inventory form, Immunization certificate and physical exam completed by their health care provider. Be sure that both **Part I (Parents)** and **Part II (health care provider)** are complete. **ALL students** attending Beth Tfiloh Dahan Community School must complete the Beth Tfiloh Health Questionnaire every year. **BALTIMORE COUNTY LAW MANDATES THAT ALL FORMS MUST BE TURNED IN ON OR BEFORE THE FIRST DAY OF SCHOOL.**

A National School of Excellence

If there is any information about your child that you would like to discuss with our health team, please feel free to call or send a note with your completed forms.

Thank you for your time; we appreciate working with you so that we may provide the best possible care for your child.

THE BETH TFILOH HEALTH AND WELLNESS TEAM

Middle & High School
410-484-5073
Judy Elbaum RN
Nancy Levine RN

PreSchool & Lower School
410-413-2512
Wendy Quartner RN
Stacy Schwartz RN CPNP

Debbie Disney LCSW-C 410-413-2326

MS Fax 410-415-5280
HS Fax 410-653-7224

PS Fax 410-415-5280
LS Fax 410-526-6753

Beth Tfiloh Dahan Community School

2010-2011 Annual Medical Statement

BETH TFILOH HEALTH QUESTIONNAIRE

STUDENT'S NAME:___________________________________ **ENTERING GRADE:**_____________

MEDICAL HISTORY:

Does your child have a history of any of the following? Please circle all that apply and explain

- Allergies/Type **Y N**
  - Allergic to: ____
  - Expected reaction ____
  - Treatment ____
  - * Reminder: All meds that your child may need at school must be provided and accompanied by a doctor's order.
- Asthma **Y N** Inhaler/Nebulizer used at school: ______
- Attention disorder/ADHD **Y N** ______________________________________
- Bladder/bowel concerns **Y N** ______________________________________
- Dental Concerns **Y N** ______________________________________
- Fainting **Y N** ______________________________________
- Frequent nosebleeds **Y N** ______________________________________
- Frequent or severe headaches **Y N** Medication used:____________________

  If yes, how frequent length/duration ______________________________________
- Frequent stomach aches **Y N** ______________________________________
- Head Injury or concussion **Y N** ______________________________________
- Heart condition **Y N** ______________________________________
- Hearing Problems **Y N** ______________________________________
- Learning differences **Y N** ______________________________________
- Menstrual Cramps **Y N** ______________________________________
- Seizures or epilepsy **Y N** ______________________________________
- Serious injury, illness, or hospitalization **Y N** ______________________________________
- Vision concerns **Y N** ______________________________________
- Weight fluctuations/eating disorder/special diet **Y N** ______________________________
- Other health concerns **Y N** ______________________________________

3300 Old Court Road / Baltimore, Maryland 21208 / 410-486-1905 / mail@btfiloh.org / bethtfiloh.com
Beth Tfiloh Dahan Community School is the grateful recipient of THE ASSOCIATED/Weinberg Day School Initiative

Medication or treatment taken at home. (Dosage, time, and purpose) ____________________
____

(For example: Ritalin 10 mg 7AM – ADHD)

Medication or treatment that may be needed by your child at school ____________________
____

Date of last Tetanus Vaccine:_____________
Any vaccines received within the last year: ____

SOCIAL/EMOTIONAL DEVELOPMENT:
Does your child have a history of any of the following? Please circle all that apply and provide a brief explanation in the space provided

- Aggressive behavior/Anger Management **Y N** ______________________________
- Anxiety/nervous/fears/phobias **Y N** ______________________________
- Death/Illness of close family member **Y N** ______________________________
- Difficulty making/keeping friends **Y N** ______________________________
- Easily frustrated **Y N** ______________________________
- Frequent body complaints **Y N** ______________________________
- Parental separation/divorce **Y N** ______________________________
- Recent move or other significant change **Y N** ______________________________
- Self-injurious behavior **Y N** ______________________________
- Shy or withdrawn **Y N** ______________________________
- Sleep difficulty **Y N** ______________________________
- Speaks unclearly/stutters **Y N** ______________________________
- Social Skills **Y N** ______________________________

Is your child receiving mental health support? **Y N** With whom? ____________________

Does your child receive speech, occupational, or physical therapy?
If not, do you feel your child would benefit from the above?
____

Is there any additional information regarding your child that you would like to share with the school? ____
____

Doctor's Name ______________________________Phone#___________________________

Dentist's Name _____________________________Phone# ___________________________

I hereby give permission for my child ______________________________to receive any medication listed below on this form as deemed necessary by the School Nurse. I have checked those medications I wish to be made available to my child. I understand that generic equivalent medications will be used in place of more expensive brand-name items.

Please check any medications you wish to be made available to your child:

For Headache/Fever/Earache/
Muscle Aches/Pain/Menstrual Cramps

☐ Acetaminophen
(like: Tylenol)

☐ Ibuprofen
(like Advil, Motrin)

For Bites/Allergic Rashes/Cuts and Scrapes

☐ Hydrocortisone Cream – 1%
☐ Anti-Itching Lotion
☐ Bacitracin

For digestive discomfort:
☐ Tums
☐ Benadryl (for allergic reactions only)
☐ Sunscreen

☐ **I do not want any medication given to my child in school.**

____ ______________
Signature of Parent or Guardian **Date**

Home Phone _________________________ **Work/Emergency Phone** ____________________________