

Student Health/Emergency Information



Student Name: _____

Last Name

First Name

Middle

Teacher: _____ **Grade:** _____ **Date of Birth:** _____ **Gender: M F**

This permission will remain in place for the duration of your child's enrollment. In the event of a critical emergency the parent/guardian will be contacted first, if possible. If we are unable to contact the parent/guardian, the emergency ambulance service will be utilized. In a critical emergency, I understand that my child will be taken to the closest hospital at the discretion of the emergency medical service (EMS). I accept full financial responsibility for charges connected with the use of an ambulance and for charges connected with the care at the hospital.

Does Your Child Have:	No	Yes	Please Specify:	List Treating Physician:
Allergies	No	Yes		
Food	No	Yes		
Drug	No	Yes		
Other	No	Yes		
Allergy Requiring Epi-Pen	No	Yes		
Asthma	No	Yes		
Epilepsy/Seizures	No	Yes		
Diabetes	No	Yes		
Insulin	No	Yes		
Heart Condition	No	Yes		
Kidney Disease	No	Yes		
Severe Nosebleeds	No	Yes		
Orthopedic Problems	No	Yes		
ADD / ADHD	No	Yes		
Anxiety	No	Yes		
Autism	No	Yes		
Bipolar	No	Yes		
Depression	No	Yes		
Emotional Condition	No	Yes		
Serious Illness / Hospitalization	No	Yes		
Glasses or Contacts	No	Yes		
Hearing Loss	No	Yes		
Hearing Aid or Cochlear Implant?	No	Yes		
Need Restrictive PE? If yes requires doctor documentation.	No	Yes		
Daily Medication	No	Yes		
Medication at School	No	Yes		
Other Health Conditions not listed.	No	Yes		

I hereby state that I have read and fully understand and agree to the Dispensing Medication policy (noted on back) regarding the administration of any type of medication to my child during school hours. I agree to release the District and/or all District personnel from liability for any and all injuries that may result from my child taking or neglecting to take medicine prescribed.

In the best interest of my child, I agree to the sharing of medical information with school faculty and staff on a need to know basis, including but not limited to medications, diagnosis, and physical restrictions or limitations.

Print Parent Name

Parent Signature

Date

INFORMATION ON DISPENSING MEDICATION AT SCHOOL

In case you are unfamiliar with school's policy on the administration of medication to students by school personnel, we would like to bring you up to date on this matter. If your child must have medication of any type given during school hours, including over-the-counter drugs, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s);
2. You may obtain a copy of a medication form from the school nurse or school secretary. Take the form to your child's doctor and have him/her complete the form by listing the medication(s) needed, dosage, and number of times per day the medication is to be administered. This form must be completed and signed by the physician for both prescription and over-the-counter drugs.

All medicines must be delivered to school by the parent/guardian or a responsible adult. It must be in the pharmacy-labeled bottle which contains instructions on how and when the medication is to be given and should not exceed a 30-day supply. Over-the-counter drugs must be received in the original container and will be administered according to the doctor's written instructions. Or

3. You may discuss with your doctor an alternative schedule for administering medication (e.g., outside of school hours).
4. In the event of your child attending a field trip, a single dose of medication will be administered by a trained school employee.

There will be no exception to this policy. If you have questions about the policy, or other concerns related to the administration of medication in the schools, please contact your building's school nurse.

Thank you for your cooperation.