

Student Name _____ Grade ____ Teacher _____

Medical Information

Does your child have any health problems of which we should be aware of? Check all that apply.

- | | | | |
|------------|--------------|---------------|-------------------------|
| Bee Stings | Food Allergy | Skin Disorder | Diabetes |
| Asthma | Eye Problems | Nose Bleeds | Heart Condition |
| Migraines | Ear Problems | Seizures | Kidney/Bladder Problems |
| ADD/ADHD | Other _____ | | |

If you have checked any of the above, please specify: _____

Does your child require an EPI PEN? _____ Where should pen be located? _____

Does your child take any prescribed medications routinely? List _____

Is Medication required during school hours? Yes No **If yes, please complete the necessary authorization form from the school nurse.**

Other important health information: _____

Child's Healthcare Provider _____ Phone _____

School clinic personnel have my permission to contact my child's physician for further medical information. I also give permission for the school clinic personnel to perform screenings and/or rescreens throughout the year as needed (hearing, vision, dental, and scoliosis) as well as participate in the growth and development presentation. The above screenings are required by law, unless I otherwise request an exemption in writing to my child's school clinic personnel.

In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the closest hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child, _____.

Parent Signature _____ Date _____

NOTE: Parent/Guardian is responsible for bringing meds such as Inhalers, Epi-pens, Benadryl, etc. to treat asthma, allergic reactions, or other medical conditions, etc. to the school.

****The school does NOT keep any medications in stock for students.****
****Any medication, including over the counter, taken daily for 2 or more weeks must have written instructions from physician.**

****Please complete the necessary authorization form from the school nurse upon providing medication to be administered at school.**