STUDENT HEALTH INFORMATION
2018-2019

To be updated and signed by parent or guardian every school year.

Name of Student: _____ Sex: M / F
Last *First* *Middle* *(circle)*

Date of Birth: ____/____/____ Grade: _____ Today's Date: ____/____/____
Month Day Year *Month Day Year*

NOTICE TO PARENTS: If your child has a health condition, it is vital that you discuss this with the school nurse and your child's teacher(s) immediately. *It is very important to know of potentially life threatening conditions* such as asthma, diabetes and severe allergies for which an individual school health care plan will be developed. In order to provide a safe and healthy environment for your child, this ***CONFIDENTIAL*** health information will be shared with appropriate school staff on a "need to know" basis.

A. MEDICAL HISTORY: ★ *CHECK* **(☑)** *below if your child has a history of any of the following health conditions. Give details in comments section as needed.*

☐ ADD/ADHD	☐ Hearing problem	☐ Seizures
☐ Anaphylaxis (severe allergy)	☐ Heart condition	☐ Skin condition
☐ Anxiety/Panic attack	☐ Kidney/Urinary problem	☐ Social/Emotional concern
☐ Asthma/Reactive airway	☐ Measles: mo/year _____	☐ Stomach aches
☐ Chickenpox: mo/year _____	☐ Mumps: mo/year _____	☐ Travel/Motion sickness
☐ Diabetes	☐ Musculoskeletal concern	☐ Vision problem
☐ Headaches	☐ Neurological concern	☐ Other *(explain below)*

_____

B. List and give dates of any **OPERATIONS, INJURIES or HOSPITALIZATIONS:** _____

_____

C. ALLERGIES: Yes ☐ No ☐ ★ *If your child has a* ***medication, food or environmental allergy*** *(such as insect stings, pollen, or mold), describe the cause of the allergy and treatment. Use additional page as needed.*

Cause of the allergy	Treatment

D. MEDICATION: Yes ☐ No ☐ ★ *If your child routinely takes any prescription, non-prescription and traditional or herbal medications, give the name of the medication and what condition it is taken for.*

Name of the medication	Used to treat	Taken at school?
1.		Yes ☐ No ☐
2.		Yes ☐ No ☐

★ ***Before medication can be administered (given or taken) at school****, a medication administration form must be completed by the parent and physician and kept on file at school.*

E. Does your student wear **EYEGLASSES?** Yes ☐ No ☐ *and/or* **CONTACT LENSES** Yes ☐ No ☐

F. Does your student wear **DENTAL BRACES?** Yes ☐ No ☐ *and/or* **DENTAL RETAINER** Yes ☐ No ☐

I hereby certify that my child is physically fit to attend school and fully participate in the school program, including physical education classes and scheduled after school activities.

Signature of Parent/Guardian: _____ **Date:** _____

Name of Parent/Guardian: _____

STUDENT HEALTH CARE CONSENTS
2018-2019

To be updated and signed by parent or guardian every school year.

Name of Student: _____ Sex: M / F
Last *First* *Middle* *(circle)*

Date of Birth: ____/____/____ Grade: _____

A. EMERGENCY TREATMENT AGREEMENT AND CONSENT

I hereby certify that my child is physically fit to attend school and fully participate in the school program, including physical education classes and scheduled after school activities. While I expect the school authorities to exercise reasonable precautions to avoid injury, I understand that the school has no financial obligation for any injury or illness that may occur during school-related physical activities.

I authorize and direct the school authorities to administer emergency treatment and to send my child to a medical facility in the event of an emergency, when immediate observation or treatment is deemed necessary in the judgment of the school nurse/authorities, and I shall not hold the school nurse/authorities liable in a court of law. I understand that in the event of a medical emergency, every effort will be made to notify the parents or guardians as soon as possible.

Signature of Parent/Guardian: _____ **Date:** _____

Name of Parent/Guardian: _____

B. MEDICATION CONSENT

During school hours and scheduled after-school and sports activities, your child may suffer an injury or illness for which the following medications will be available, under the supervision of the school nurse or coach. Draw a line through/cross out any medication you **do not want** your child to be given. Any medications not crossed out **will indicate permission** for the nurse or coach to administer the medication without contacting the parent.

Oral Medications

- Strepsil throat lozenges for sore throat (age 5 years and older)
- Oral rehydration solution (Naya Jeevan) for hydration, rehydration
- Bismuth salicylate (Pepto Bismol) for stomach upset, nausea, diarrhea (age 12 years and older)
- Antacid (Digene) for heartburn, stomach acidity
- Ibuprofen (Motrin, Advil, Brufen) for fever, pain, inflammation due to injury
- Paracetamol (Tylenol, Cetamol, Niko) for fever, pain

Topical Medications

- Betadine (povodine iodine) antiseptic solution for cleaning superficial skin wounds
- Polysporin or Neosporin antibiotic ointment for superficial skin wounds
- Calamine lotion for skin rash/reaction from allergies, nettles, insect bites, etc.
- Sterile normal saline for flushing the eye
- Lubricating eye drops (Refresh Plus) for lubricating the eye
- Moov (wintergreen-nilgiri) ointment and Arnica-witch hazel gel for bruises, muscle and joint pain

Signature of Parent/Guardian: _____ **Date:** _____

Name of Parent/Guardian: _____

G. HEALTH CARE PROVIDERS

Name of Local **Physician**: _____ Phone: _____

Address/Location: _____

Name of Local **Dentist**: _____ Phone: _____

Address/Location: _____