2017/2018 EMERGENCY HEALTH INFORMATION

(Please use black or blue ink for copying purposes) (2 Sided Form – See reverse side)

Student's Last Name Student's First Name

Student's Address City Home Phone

Date of Birth Grade Family Physician Hospital Preference

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Emergency Contacts:

Parent/Guardian Name Home # Cell # Work #

Parent/Guardian Name Home # Cell # Work #

Additional Emergency Contact (Relationship) Phone #

PERMISSION FOR NON-PRESCRIPTION MEDICATION			
I authorize the Nurse or School Personnel under the supervision of the school nurse to give the following NON-prescription medication **checked** to my child *if needed* during school hours.			
_____	TYLENOL	*as directed on label	*every 4 hours as needed*
_____	ANTACID	*as directed on label	
_____	BENADRYL tab/liquid	*as directed on label	*EMERGENCY ONLY*

I give my permission for the above student to receive first aid and palliative care in the Health office as needed. This may include application of bandages, OTC creams and ointment, ice packs, sunscreen lotion, oragel, throat spray, cough drops, lip balm, Sting kill/ease, etc. I have notified Health Services in writing of Allergies, Health Concerns, and Daily medications. I have read and understand the medication policy.

I give permission to participate in Health Screenings and Health Education as required/recommended by the State and South Newton School Corporation.

***Parent/Guardian Signature Date

Turn form over

Health History

If you answer YES to any of the questions below, use Comment section

		COMMENTS:
Does your child have a history of allergies?	YES NO	**If YES, Describe Allergy/Reaction**
Is your child allergic to any medications?	YES NO	**Describe Allergy// Reaction//Treatment**
Does your child wear glasses or contact lenses?	YES NO	***Last date seen by eye doctor: _____**
Does your child have a history of hearing loss?	YES NO	
Does your child wear hearing aids?	YES NO	***R / L / Both***
Does your child have history of frequent ear infections?	YES NO	
Does your child have asthma-currently being treated with meds?	YES NO ***IF YES, SEE NURSE.***	***INHALER? YES NO*** ***NEBULIZER? YES NO*** ****Asthma Action Plan required by MD/PCP**
Does your child have a history of seizures?	YES NO ***IF YES, SEE NURSE.***	***Describe Seizures:*** ***Date of last seizure:***
Does your child have a history of diabetes?	YES NO ***IF YES, SEE NURSE.***	****Updated Diabetic Plan required by MD/PCP**
Does your child have history of stomach problems or ulcers?	YES NO	
Does your child have a history of migraines?	YES NO	***IF YES, SEE NURSE.***
Has your child ever had chicken pox ?	YES NO	***If YES, Month/Year: _____***
Is your child allergic to bee stings that require an EPIPEN?	YES NO ***IF YES, SEE NURSE.***	***DESCRIBE REACTION:*** ****EPIPEN order required by MD/PCP***
Does your child have ADD?	YES NO	***MEDS. REQUIRED AT SCHOOL? YES NO***
Does your child have ADHD?	YES NO	***MEDS. REQUIRED AT SCHOOL? YES NO***
Does your child have a history of frequent nose bleeds?	YES NO	
Does your child have a history of a heart condition?	YES NO	
Does your child have a history of a renal condition?	YES NO	
Does your child have history of an orthopedic condition?	YES NO	
Does your child have any other health conditions? (including chronic conditions)	YES NO	
May we call any of your child's Doctor's if needed?	YES NO	

List ANY and ALL medications that your child is currently taking below:

MEDICATION DOSAGE REASON WHY TIME GIVEN

_____

_____

_____