Child's Name_____ Birthdate_____Age_____Grade_____
Parent/Guardian Name_____ Phone #:_____
Place of Work_____Phone #_____
Emergency Contact_____Phone #_____
Insurance Provider_____Policy #_____

2019-2020
Student Health Information

Medical History: (Please check all that apply)

____Yes ____No	Asthma/lung problems	____Yes ____No	Seizures
____Yes ____No	ADD/ADHD/Behavioral Issues	____Yes ____No	Headaches
____Yes ____No	Heart Problems/Irregularities	____Yes ____No	Hearing Deficit
____Yes ____No	Urinary/Bladder Problems	____Yes ____No	Diabetes
____Yes ____No	Stomach/Bowel Problems	____Yes ____No	Skin Conditions
____Yes ____No	Surgeries/Injuries/Broken Bones	____Yes ____No	Glasses/Contacts
____Yes ____No	Other, if yes please explain	____Yes ____No	Tetanus shot

Comments to any marked above:_____
_____
****

Medication: Does your child take any medication/treatments regularly? ____Yes ____No (If yes, please list)

Name of Medication:	Dose:	Time Given:	Reason:	To be given at school Y/N?
1.				
2.				
3.				

****Any medication administered at school requires written authorization. Over the counter medications must be in the original container and prescription medications must in the pharmacy's bottle with the correct label.**

Allergies (food, medication, latex, environmental): _____
_____
What kind of reaction does the child have to this allergy? _____
_____
* Please contact the school nurse if your child's food allergy requires an Epi-Pen. The Epi-Pen needs to be at the school on the first day.

Primary Physician_____ Phone #_____

Preferred Hospital_____Dentist_____Phone #_____
****

As the parent/guardian I authorize basic first aid and emergency medical treatment if necessary in the event of an accident or illness of my child. I understand that all efforts will be made to contact me in the event of an emergency. I give my permission for the school nurse to share relevant health information to appropriate school staff when needed to meet the child's health and safety needs. I give my permission to medical professionals to exchange information for the purpose of referral, diagnosis, and treatment with the MVAO school nurse. I give specific permission to my health care provider to share any pertinent health information in my child's health record regarding: immunizations, administration of medications, and/or educationally significant health information that may affect my child's learning and/or safety at school.

_____ _____
Parent/Guardian Signature **Date**