SCHOOL HEALTH INFORMATION

Dear Parent/Guardian: It is important that this information be updated **yearly on all students.** Please complete this form and return it to school as soon as possible.

STUDENT INFORMATION		
NAME:	DATE OF BIRTH:	SEX: M_____F_____
ADDRESS: CITY:		STATE:
SCHOOL:	TEACHER:	GRADE:
PHYSICIAN NAME: DENTIST NAME:	PHYSICIAN PHONE NUMBER: DENTIST PHONE NUMBER:	
CUSTODY ORDERS: _____YES _____NO (MUST PROVIDE COPY OF ORDERS)		

EMERGENCY CONTACT INFORMATION			
(1)PARENT/GUARDIAN:	HOME:	WORK:	CELL:
(2)NAME & RELATIONSHIP	HOME:	WORK:	CELL:
(3)NAME & RELATIONSHIP	HOME:	WORK:	CELL:
(4)NAME & RELATIONSHIP	HOME:	WORK:	CELL:
(5)NAME & RELATIONSHIP	HOME:	WORK:	CELL:
Please check: BUS RIDER_____(Bus #_____) CAR RIDER_____			

HEALTH INSURANCE INFORMATION	
NAME OF INSURANCE:	**POLICY NUMBER**:
MEDICAID _____ YES _____ NO	#
FAMIS _____ YES _____ NO	#
PRIVATE (list name):	#

Please see the Scott County School Website:
*{**www.scottschools.com/resources/for_parents/health_forms**} for "Clinic Guidelines", "Medication Policy" and other health & safety recommendations. All medical forms are also accessible at this site.*

In case of accident or serious illness, I request the School to contact me. If the school is unable to reach me, I hereby authorize Scott County School personnel to arrange transportation for my child to receive emergency medical treatment. I further authorize any physician to provide whatever emergency care may be necessary to insure the health and safety of my child. Important medical information about my child may be shared with appropriate school personnel for the safety & wellbeing of my child. (ie: child's teachers, bus & lunch duty staff, cafeteria staff)

(Signature of Parent/Guardian) _____ Date)_____

BRIEF MEDICAL HISTORY

If your child has a severe allergy that can be <u>life-threatening</u>, you must provide the school with emergency medication (Epinephrine) or you must sign a waiver if you choose not to provide the necessary medication.

Please list any health conditions that your child has that may put him/her at risk for a medical emergency: (ie: asthma, diabetes, severe allergies, seizure disorder) **(A <u>Plan of Care</u> may be implemented for some illnesses and forms will be sent home for you to complete and return to your child's school nurse.)**

_____
_____
_____

1. Please list any medications that your child takes and indicate if this medication will be taken at SCHOOL**: (A "Doctor's Order" form will be sent home for your child's physician to complete if medication is to be taken at school.)**

   _____
   _____
   _____

2. If your child is currently under a physician's care please notify us of any medical concerns and provide us with physician's name and phone in case of emergency:

   _____
   _____
   _____

OVER THE COUNTER MEDICATION: MAXIMUM DOSES = 5 PER YEAR AFTER 5 DOSES, MUST HAVE MD ORDER.

{FOR OFFICE USE ONLY:}

MEDICATION					
TYLENOL OR MOTRIN (OR GENERIC)	CIRCLE T OR M DOSE _____ DATE/TIME/INITIALS _____ _____ _____	CIRCLE T OR M DOSE _____ DATE/TIME/INITIALS _____ _____ _____	CIRCLE T OR M DOSE _____ DATE/TIME/INITIALS _____ _____ _____	CIRCLE T OR M DOSE _____ DATE/TIME/INITIALS _____ _____ _____	CIRCLE T OR M DOSE _____ DATE/TIME/INITIALS _____ _____ _____

***I give permission for the Scott County School Personnel to administer**:

Tylenol (Or Generic) _____ (yes) _____(no) Dosage: _____

Ibuprofen (Or Generic) _____ (yes) _____(no) Dosage: _____

_____

(Parent/Guardian Signature) (Date)