Revised 5-17-17

Please fill out and return to the school nurse: School Year: _______________

Grade: ______________ Date of birth: _______________ Male ____ Female ____

Name: ____
(Last) (First) (Middle)

Address: ____ City: __________________ Zip: __________

Health insurance status:

No health insurance _____

Private insurance _____ Company: ____

Medicaid program _____ Medicaid #: ____

Doctor's name: _______________________________________ Phone # __________________________

Dentist's name: ____ Phone # _________________________

Hospital preference: ____

Date of last physical: ___________________________ Last dental exam: _______________________

Is your child under the care of an orthodontist? ___________

Does your child have?	(Answer yes or no)	Please specify and explain:
ADD/ADHD	______	__________________________
Allergies	______	__________________________
Food Allergy	______	__________________________
Bee Sting Allergy	______	__________________________
Asthma	______	__________________________
Diabetes	______	__________________________
Takes Insulin	______	__________________________
Ear Infections	______	__________________________
Epilepsy/Seizures	______	__________________________
Heart Condition	______	__________________________
Orthopedic Problem	______	__________________________
Kidney Problem	______	__________________________
Scoliosis	______	__________________________

Other problems ____

Has your child had?	(Answer yes or no)	
Serious illness	______	__________________________
Serious injury	______	__________________________
Surgery/Operation	______	__________________________
Fracture/Broken Bone	______	__________________________

(Please turn over and complete the other side.)

Does your child –

Have trouble seeing close work? ______ Wear glasses? ______

Have trouble seeing at a distance? ______ Wear contact lenses? ______

Have trouble hearing? ______ Wear a hearing aide? ______

Have a condition that prevents participation in regular PE? ______

If yes, please specify: ____

Does your child take medication? ______

At home? ______

At school? ______

Please list all medication:

Daily medications: ____

____

As needed' medications: ____

____

UNUSUAL HEALTH CONDITIONS? Yes ______ No ______

If yes, please explain:

____

Has your child had a tetanus shot or any other immunization updated in the past year?

Yes ______ No ______

My child is allowed to take part in vision, hearing and growth screenings during the school year.

Yes _____ No_____

______________________________ ______________________________

Parent/Guardian Signature Date

I give my permission for the nurse or trained designee to administer the medications indicated below for my child's minor illness, injuries or complaints of discomfort according to the package indications and dosing instructions:

Tylenol / Acetaminophen	_____ Yes	_____ No
Advil / Motrin / Ibuprofen	_____ Yes	_____ No
Cough / throat drops	_____ Yes	_____ No

______________________________ ______________________________

Parent/Guardian Signature Date

In case of serious illness or injury, and if none of the emergency contacts I have provided can be contacted, the school nurse, building principal or district superintendent is hereby authorized to take/send my son/daughter to a physician or hospital for treatment according to their best judgment. I will be accountable for medical services incurred.

______________________________ ______________________________

Parent/Guardian Signature Date