HEALTH INFORMATION FORM

Student_____ Grade____ Year_____ Teacher_____

Address_____City_____ Zip_____

M F DOB_____ Type of Health Care Insurance: Medicaid____ Peachcare____ Other/Private_____

Dental Insurance ____Yes ____ No Vision Insurance ____ Yes ____No

Medical conditions for which student is being treated by a medical provider include (Please circle)

Diabetes Asthma Sickle Cell Disease Cancer Seizures Hydrocephalus with Shunt

List other medical conditions currently being treated by a medical provider: (Please include any implantable medical devices such as a defibrillator, pacemaker, cochlear implants or vagal nerve stimulator) _____
_____

- Medical conditions requiring special medical treatment and/or staff training, other than standard first aid, will require written physician guidelines. Please provide the written physician guidelines to your school's health monitor who will forward the guidelines to your school's Registered Nurse (RN).

List current medications prescribed by physician: _____
_____

- If student has been prescribed an emergency medication (Epi-Pen, Diastat, inhaler, etc.) parent/guardian must provide the emergency medication to the school along with the permission forms.

List known student allergies: _____
_____

- If student requires a special diet at the school, please pick up a special dietary needs form for your physician to complete. Completed forms should be returned to the school's health monitor who will forward to the appropriate administrator.

Student's Physician _____ Phone _____
Student's Dentist _____ Phone _____

EMERGENCY CONTACT INFORMATION

Mother/Guardian_____ Phone (Home)_____Cell_____
Phone (Work)_____

Father/Guardian_____ Phone (Home)_____Cell_____
Phone (Work)_____

<u>If parents cannot be reached, list two nearby persons who will assume care of your child.</u>

Name_____ Relationship_____Phone_____

Name_____ Relationship_____Phone_____

AUTHORIZATION FOR EMERGENCY TREATMENT

In case of serious illness/injury, I understand that the school will telephone Emergency Medical Services (911) for assessment and immediate transportation to the closest hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child _____.
Fees for transportation and medical services will be the responsibility of the parent/guardian.

Parent/Guardian Signature_____ Date_____

Parent/Guardian Email _____