

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:	PHYSICIAN 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 life-threatening, you must provide the school with emergency medication (Epinephrine) or you must sign a waiver if you choose not to provide the necessary medication.

1. 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 Plan of Care may be implemented for some illnesses and forms will be sent home for you to complete and return to your child's school nurse.)**

2. 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.)**

3. 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 _____	CIRCLE T OR M DOSE _____	CIRCLE T OR M DOSE _____	CIRCLE T OR M DOSE _____	CIRCLE T OR M DOSE _____
	DATE/TIME/INITIALS _____	DATE/TIME/INITIALS _____	DATE/TIME/INITIALS _____	DATE/TIME/INITIALS _____	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)