Student Health History & Emergency Medical Treatment Consent Form School Year _____

Student		School	Grade/Teacher
Address		Birth Date	Gender
Parent/Guardian/Emergency Contacts	**Relationship**	**☎ Phone**	
Call 1st:		Home:	Cell:
		Work:	
Call 2nd:		Home:	Cell:
		Work:	
Call 3rd:		Home:	Cell:
		Work:	

Student's doctor/healthcare provider: _____ **Phone:** _____

Insurance Information: _____
(Include Group's Name, ID Number, Group Number, and Subscriber)

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:
If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies	☐	☐	List:
Food Allergies	☐	☐	Food(s): ☐ peanut ☐ dairy ☐eggs ☐other _____ Rate the reaction: ☐mild ☐moderate ☐ life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergy to Bees Stings	☐	☐	Rate the reaction: ☐mild ☐moderate ☐ life-threatening Does your child require an EpiPen? ☐yes ☐no
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Rate the severity: ☐mild ☐moderate ☐ life-threatening Asthma medication taken at home: Medication required at school:
Diabetes	☐	☐	☐Type 1 (Insulin Dependent) ☐Type 2 Diabetes medication(s) taken at home:
Seizure Disorder	☐	☐	Type of Seizure: Medications: _____
Neurological Disorder	☐	☐	Specify:
Heart Condition	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
Cancer	☐	☐	Specify: Treatment:
Bowel/Bladder Issues	☐	☐	Specify:
Migraine Headaches	☐	☐	Triggers: Treatment:
Bone/Muscle Problems	☐	☐	Specify: Activity Restrictions:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health Behavioral Issues	☐	☐	Specify: Treatment/Medication:
Wears Glasses/Contacts	☐	☐	☐Glasses ☐Contacts → ☐For Distance ☐For Reading
Hearing Loss	☐	☐	☐Hearing Loss Right Ear ☐Hearing Loss Left Ear ☐Hearing Aid(s)
Other Serious Illness	☐	☐	Specify: Date of Onset:
Serious Injury	☐	☐	Specify: Date(s):
Surgery	☐	☐	Specify: Date(s):
Medication Taken at Home *(if not already listed)*	List:		

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstance.

_____ _____ _____
PARENT/GUARDIAN SIGNATURE *PRINTED NAME* *DATE*

Rev. 4/2009 *Reviewed by School Nurse:*

ALPHA PUBLIC SCHOOL

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SCOLIOSIS SCREENINGS ARE REQUIRED OF ALL 5TH AND 7TH GRADE STUDENTS.

- I do wish to have my child included in the scoliosis screening program.
  Yes _____ No _____

- I will have my 5th or 7th grade child examined by our family physician **AND SUBMIT THE REPORT TO THE SCHOOL NURSE.**
  Yes _____ No _____

PERMISSION FOR RELEASE OF HEALTH INFORMATION

This release authorizes the school nurse to send or receive pertinent medical information necessary for my child's health, well-being and safety. This authorization is valid for one year.

Student's Name: _____

Date of Birth: _____

Grade/Teacher: _____

Parent/Guardian's Name (MUST PRINT): _____

Parent/Guardian's Signature: _____

Date: _____