Student Health History & Emergency Medical Treatment Consent Form **School Year 2022 - 2023**

Student:	**School: Alpha**	**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 #, Group # & 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:
Allergies (other)			List:
Food Allergies			Food(s): Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Allergy to Bee Stings			Rate the Reaction: Mild Moderate Life-Threatening Does your child have an EpiPen? Yes No
Asthma			Rate the Severity : Mild Moderate Life-Threatening Asthma medication taken at home: Medication required at school:
Diabetes			Type 1 (Insulin Dependent) Type 2 Medication Required at School:
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 Aides
Other Serious Illness			Specify: Dates 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 confidentiality with school staff and emergency responders as needed. In the event of 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

Reviewed by School Nurse:_____