2016/2017 EMERGENCY HEALTH INFORMATION

(Please use black or blue ink for copying purposes) **(2 Sided Form – See reverse side)**

Student's Last Name Student's First Name

Student's Address City Home Phone

Date of Birth Grade Family Physician Hospital Preference

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***Emergency Contacts*:**

Parent/Guardian Name Home # Cell # Work #

Parent/Guardian Name Home # Cell # Work #

Additional Emergency Contact (Relationship) Phone #

PERMISSION FOR NON-PRESCRIPTION MEDICATION

I authorize the Nurse or School Personnel under the supervision of the school nurse to give the following NON-prescription medication **checked** to my child *if needed* during school hours.

_____	TYLENOL	*as directed on label	*every 4 hours as needed*
_____	ANTACID	*as directed on label	
_____	BENADRYL tab/liquid	*as directed on label	*EMERGENCY ONLY*

I give my permission for the above student to receive first aid and palliative care in the Health office as needed. This may include application of bandages, OTC creams and ointment, ice packs, sunscreen lotion, oragel, throat spray, cough drops, lip balm, Sting kill/ease, etc. I have notified Health Services in writing of Allergies, Health Concerns, and Daily medications. I have read and understand the medication policy.

I give permission to participate in Health Screenings and Health Education as required/recommended by the State and South Newton School Corporation.

*****Parent/Guardian Signature Date**

Turn form over

Health History

If you answer YES to any of the questions below, use Comment section

			COMMENTS:
Does your child have a history of allergies?	YES	NO	**Describe Allergy/Reaction**
Is your child allergic to any medications?	YES	NO	**Describe Allergy// Reaction//Treatment**
Does your child wear glasses or contact lenses? (circle one)	YES	NO	***Last date seen by eye doctor:*** _____
Does your child have a history of hearing loss?	YES	NO	
Does your child wear hearing aids?	YES	NO	***R/L/Both***
Does your child have history of frequent ear infections?	YES	NO	
Does your child have asthma-currently being treated with meds?	YES	NO	***INHALER?*** ***YES NO*** ***NEBULIZER?*** ***YES NO***
Does your child have a history of seizures?	YES	NO	***Describe Seizures:*** ***Date of last seizure:***
Does your child have a history of diabetes?	YES	NO	
Does your child have history of stomach problems or ulcers?	YES	NO	
Does your child have a history of migraines?	YES	NO	
Has your child ever had chicken pox ?	YES	NO	***If YES, Month/Year:*** _____
Is your child allergic to bee stings? ***(Describe Reaction)***	YES	NO	***EPIPEN REQUIRED?*** ***YES NO***
Does your child have ADD?	YES	NO	***MEDS. REQUIRED AT SCHOOL?*** ***YES NO***
Does your child have ADHD?	YES	NO	***MEDS. REQUIRED AT SCHOOL?*** ***YES NO***
Does your child have a history of frequent nose bleeds?	YES	NO	
Does your child have a history of a heart condition?	YES	NO	
Does your child have a history of a renal condition?	YES	NO	
Does your child have history of an orthopedic condition?	YES	NO	
Does your child have any other health conditions? (including chronic conditions)	YES	NO	
May we call any of your child's Doctor's if needed?	YES	NO	

If your child is on **ANY** medications please list below:

MEDICATIONS	**DOSAGE**	**REASON**	**TIME GIVEN**