Grade: _____ Student Name: _____ Male / Female Age: _____ Date of Birth: _____

St. Marys Area School District Health Information and Medical Services Authorization

This authorization will be considered valid from August 2019 until October 15, 2020

The following information must be updated annually in order for school health service providers to administer effective medical attention to your student.
Information provided on this form may also be shared for educational purposes, school related activities, and school sponsored outings.

*** If this form is not completed and returned in a timely manner, NO MEDICAL SERVICES CAN BE PROVIDED TO YOUR STUDENT.**

Name of parent/guardian with whom student resides: **Student resides with (circle one) Both Parents * Father * Mother * Foster * Other**			**Address:** **Mark Appropriate form of custody (if applicable) Shared or Sole Custody**		
Parent/Guardian	**Home Phone Number**	**Cell Phone Number**	**Employer:**	**OK to call Employer**	**Work Phone Number**
				Yes / No	
				Yes / No	

Siblings in school district:

Name:	Grade/ Teacher	School:
Name:	Grade /Teacher	School:
Name:	Grade /Teacher	School:

Does your student *CURRENTLY* have any of the following health conditions? Check all that apply. OR ☐ No known medical problems

☐ ADD ☐ ADHD ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Cystic Fibrosis ☐ Tourette's Syndrome ☐ Cerebral Palsy ☐ Spina Bifida
☐ Autism ☐ Anxiety ☐ Depression ☐ Arthritis/Rheumatic disease ☐ Scoliosis ☐ Anemia or Bleeding Disorder ☐ Sickle Cell Anemia/Trait
☐ Dental Problems ☐ Vision Problems ☐ Wears Glasses? ☐ Contacts? ☐ Eye Patch ____left ____ right
☐ Hearing Difficulty ☐ Hearing aid____ left ____ right ☐ Ear Tubes? ___ left ___right ☐ Cancer, Describe:_____
☐ Gastrointestinal Problems, Describe: _____ ☐ Menstrual Problems
☐ **Allergies (specify type by checking) ☐ Medication ☐ Environmental ☐ Seasonal ☐ Food. List Allergen: _____**
Describe Reaction:_____ ☐ *Needs Epi-Pen at school? ☐ Yes ☐ No (Requires a physician order and written parental consent)
My child requires food substitutions at school (Requires a completion of form from Nutrition Services): ☐ Yes _____ ☐ No
☐ Heart Disease, Describe: _____ ☐ Head Injury or diagnosed concussion, Describe: _____
☐ Asthma *Needs an inhaler at school? ☐ Yes ☐ No (Requires a physician order and written parental consent)
☐ Diabetes (specify type by checking): _____Type 1 (insulin dependent) _____ Type 2 (non-insulin dependent)
☐ Headaches / Migraines (circle one): Followed by a physician for this? ☐ Yes ☐ No
☐ Seizures: If yes, describe: _____ *Diastat or Versed at school? ☐ Yes ☐ No Has VNS? ☐ Yes ☐ No
☐ Recent surgery or overnight hospital stay? If yes, describe:_____
☐ Other:_____

REMINDER –ALL Medications will require a *physician order & written parental consent,* including but not limited to: epi pens, asthma inhalers, insulin, seizure medications, etc.

Medications: Please list ALL current medications your child is taking, *including medications given at home (prescription, OTC, herbs, supplements)*.

_____

_____

Will any medication need to be given in school? ☐ Yes ☐ No_____

ALL Medications will require a *physician order & written parental consent*

Student Name:_____

Please list other persons we may call for advice or direction in caring for your student in the event we are unable to contact a parent/guardian:

Name	Relationship to student	Home phone number	Cell phone number	Employer	OK to call Employer	Work phone number
					Yes / No	
					Yes / No	
					Yes / No	

Has your student received any recent immunizations? Yes / No Describe: _____

I give permission for SMASD School Nurses to contact my student's health care providers listed below for any health information regarding medical conditions, immunizations, mental health concerns, physical & dental examinations. Parent Signature: _____Date: _____

Insurance Provider and Policy Number: _____**My student does not have health insurance:** _____
Physician Name: _____ Date of last exam: _____

Dentist Name: _____ Date of last exam: _____

Eye Care Specialist: _____ Date of last exam: _____

Mental Health Care provider (if applicable) Name: _____ Date of last visit: _____

In case of emergency, if the parents cannot be contacted immediately, I give my permission to have my student transported to the nearest hospital and I will assume all expenses.
I also give permission to make information on this form available to authorized school and transporation personnel, and Office of Vocational Rehabilitation if necessary.

Parent/Guardian Signature: _____ **Date:** _____

Permission to Administer Medication

Please initial the box after EACH individual medication that you authorize school personnel to administer to your student. Medications without an initial will not be administered with the exception of Epinephrine (for suspected life threatening allergic reactions) and Narcan (SMAHS ONLY – for suspected drug overdose). If you wish to opt-out of administration of epinephrine/narcan, please contact your school's nurse to obtain the appropriate form to complete.

Medication	Initial	Medication	Initial	Medication	Initial	Medication	Initial
Acetaminophen (Tylenol or non-aspirin substitute)		Tums		Orajel /Anbesol		**Topical creams for skin irritations**- Neosporin, Callergy Clear Lotion, Hydrocortisone Cream, Burn jel, Bactine Spray, Sting swabs, Aloe Vera Gel, Sunscreen, Moisturizing Lotion, Vaseline Ointment, Blistex Lip cream	
Ibuprofen (maximum 400mg, weight based dosing)		Cough drops		Contact lens solution, Eye Wash		**Emergency Medications** Albuterol Inhaler, Benadryl **(for asthma symptoms and allergic reactions)**	

Parent Signature for permission to administer: _____ **Initial:** _____ **Date:** _____

I prefer my student does NOT receive ANY medications provided by the St. Marys Area School District. Signature: _____ **Date:** _____