PLEASE CHECK ANY HEALTH CONDITIONS YOUR CHILD HAS:

- ☐ Anemia
- ☐ Asthma/Wheezing **Inhaler Yes___ No__**
- ☐ Attention Deficit Disorder
- ☐ Cancer
- ☐ Cystic fibrosis
- ☐ Diabetes-High blood sugar
- ☐ Bronchitis/pneumonia (frequent)
- ☐ Cerebral Palsy
- ☐ Dry skin/Eczema/ Psoriasis
- ☐ Ear Infections (Frequent) hearing loss
- ☐ Headaches/Old head injury
- ☐ Heart murmur/defects
- ☐ HIV Positive/AIDS
- ☐ Hyperactivity
- ☐ Hypoglycemia-low blood sugar
- ☐ Kidney Infections (Frequent)
- ☐ Menstrual Cramps
- ☐ Mental Illness
- ☐ Nose Bleeds
- ☐ Oppositional Defiant Disorder
- ☐ Scoliosis/Curved Spine
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell
- ☐ Syncope or fainting spells
- ☐ Vomiting/Diarrhea (Frequent)
- ☐ Crohn's Disease
- ☐ Other _____ _____

DOES YOUR CHILD REQUIRE A SPECIAL DOCTOR ORDERED DIET? YES____NO____
IF YES, PLEASE SPECIFY TYPE (Documentation must be provided by a medical doctor)
_____

ARE THERE ANY PROBLEMS YOU OR YOUR CHILD WISH TO DISCUSS WITH THE NURSE?
Yes____ No_____

POSITION STATEMENT (Please read and sign accordingly)

The school health personnel will conduct screenings in the areas of vision, hearing, scoliosis, dental health, and general health. As the parent/legal guardian, I will (1) provide any prescribed medicine that needs to be administered during the school day: (2) provide a statement from the physician regarding the prescribed dosage, means of administration time to be taken during school hours, and a list of possible side effects or adverse reactions to the medicine: and (3) notify the school if there is a change in the dosage or if the medicine is no longer required.

By my signature, as parent/guardian of the above named student, I hereby give my permission for the school district to provide my child with medical care, treatment, and emergency medical services. In the event my child is injured or should require medical attention, I hereby authorize the school district to contact the physician/health care provider listed above. In the event the physician/health care provider cannot be reached, I hereby authorize the school to secure necessary medical treatment. If possible, confirmation of this authorization should be made with me prior to treatment, by calling me at the telephone number listed above. In the event I cannot be reached, or in case of an emergency medical treatment, including ambulance service, if necessary, may proceed without my authorization, I hereby agree that I will be responsible for all costs associated therewith.

_____**YES**_____**NO** I give permission for the school nurse to administer common over-the-counter medicines for routine illnesses.

_____YES _____NO I request that the school administer medication as prescribed by our physician in the form prescribed by the physician or as specified on the container issued by the pharmacy.

PARENT/GUARDIAN'S SIGNATURE_____ DATE_____

Revised 4/2017