Student Health Information and
Authorization for Emergency Medical Treatment

24-25

*We would appreciate your help in updating your child's health and emergency information **each school year** so that we can take the best possible care of him/her at school. Please fill out this information sheet, sign and return it to school.*

Student's Name *Birth Date* *Sex* *Grade*

Parent/Legal guardian Name and Address ***Daytime** Phone*

Family Doctor/Phone Number *Family Dentist/Phone Number*

Medical Insurance company / Phone number ❑ I would like assistance finding insurance for this student

STUDENT MEDICAL HISTORY:

☐	Frequent earaches, infections, colds	☐	Frequent nosebleeds	☐	Heart Condition
☐	Kidney or bladder trouble	☐	Physical defects	☐	Asthma ❑ will need meds at school
☐	Eczema/skin trouble	☐	Vision problem	☐	Diabetes
☐	Frequent headaches	☐	Speech problem	☐	Convulsions/ seizures
☐	Family history of tuberculosis	☐	Hearing problem	☐	Allergic reaction requiring meds
☐	Tuberculin test positive or treated	☐	Scarlet fever, rheumatic fever		
☐	Mental health problem	☐	Chickenpox illness_____ (mo/yr)		

Please explain special health problems: _____

ALLERGIES:

❑ plants ❑ foods ❑ bees or insect sting requiring medication
❑ drugs ❑ animals ❑ other

Please describe the allergic **reaction** and **treatment**;_____

Do your child's health problems affect his/her daily living or school participation: YES NO ***If YES, please explain***:

List and give any significant, injuries, deformities or operations:_____

Is child required to take medication or treatments **regularly**? YES NO ***If YES, please explain:***_____

Does your child wear contact lenses?_____ Glasses? _____
List any special needs for riding school bus:_____

❒ **I authorize the principal or his/her designee to transport and seek emergency medical or dental treatment** when the need for such treatment is immediate and when efforts to contact me are unsuccessful. This authorization shall remain effective for the full school year unless revoked in writing and delivered to the _____ School District. I understand that the _____ School District, its employees and its Board of Directors assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of EMS transportation, hospitalization, examination, x-ray or treatment provided in relation to this authorization shall be my responsibility.

❒ **I do NOT authorize or consent to emergency medical or dental treatment for my child**. Please relate procedure to follow if child has problems, until parents can be contacted: _____

Signature of parent/guardian **Date**

I understand that the medical information provided above will be shared, if indicated, with those who need to know in order to provide a safe environment for my child.

I understand that the _____ School District does NOT provide accident medical insurance for students for school-related injuries, but does offer student accident insurance for voluntary purchase. I have received the information and application for this program. I ❒will ❒will not enroll my child in the program.

Expires at end of current school year.

Signature of parent/guardian **Date**