Avenue City School Student Health Form 2013-2014

Your child's learning depends on good health. To assist in providing health services at school, please complete the following and return to the School Nurse.

Student Name _____Grade_____ Date of Birth_____

Mother/Guardian _____Employer_____

Phone #s: Home_____ Cell_____ Work_____

Work Days and Hours _____

Father/Guardian _____Employer _____

Phone #s: Home_____ Cell_____ Work_____

Work Days and Hours- _____

Emergency Contact:
If parent cannot be contacted in case of emergency, please contact the following person:

Name_____ Relation to child/family _____

Phone #s: Home_____ Cell_____ Work_____

In the event that your child has an accident or becomes ill at school, please list the physician to be called. All reasonable efforts will be made to contact you first!

Physician _____Phone # _____

Dentist _____ Phone # _____

Preferred Hospital _____ Phone # _____

DOES YOUR CHILD HAVE:
Allergies in General: Yes_____No_____ To medications, food, insects, pollen, etc?
Please list _____
Has the allergy required emergency action in the past? Y _____ N _____
Comments: _____

Bee Sting Allergy Yes _____No _____ Describe reaction _____
Difficult breathing? Y_____ N_____ Emergency medication needed? Y _____ N _____
If 'yes', additional form must be completed

Asthma Yes _____ No _____ Triggered by _____
Treatments _____
Diagnosing Dr. name _____ Phone # _____
If 'yes', additional form must be completed

Diabetes Yes _____ No _____ Takes insulin/medication at home? Yes _____ No _____
If 'yes', additional form must be completed

Epilepsy/ Seizures Yes _____ No _____ Describe seizures _____
Date of last seizure _____ Medications _____
Physician caring for condition _____
If 'yes', additional form must be completed

Student Name: _____

Heart Condition Yes ____ No ____ Describe _____
List any medications or restrictions _____

Bone or Joint Condition Yes ____No ____ Describe _____

Takes daily medications At home? Yes _____No _____ At school? Yes _____ No _____
Name of medication _____ Dosage _____
Time taken _____ Reason for taking _____

Other Medical Concerns? _____

Over the counter medication will no longer be provided by the school district other than the ones listed below. They may, however, be brought from home in an unopened container and locked up in the nurse's office for a student to use. Over the counter medication may be administered at school only if accompanied by written instructions as well as reason for use signed by the parent/guardian. Any over the counter medication that is required for long term use (more than two weeks) may require physician consent, if the school nurse deems appropriate. The school nurse has the right to request physician consent for ANY over the counter medication.

Peroxide/ Triple Antibiotic Ointment - for minor cuts/abrasions
Hydrocortisone 1% cream/ Caladryl Clear lotion - for minor itching/irritations
Aloe Vera Gel/ Solarcaine Spray - for minor burns
Eye Wash/ Artificial Tears/ Artificial Tears for contact wearers - for minor eye irritation
Vaseline - for dry lips
Campho-phenique/ Anbesol/ Orajel - for cold sores, fever blisters, minor mouth pain
Cough Drops - for cough, throat irritaion/ pain

*Generic Versions may be used

To dispense prescription medicine at school, the nurse must have physician's orders on file with a physician's signature and/or MUST be in original container appropriately labeled by the pharmacy. All medicine must be brought to school by parent/ legal guardian with a note signed by the parent/guardian.

The following grade appropriate screenings will be done at school, please indicate if you **DO NOT** want your child to have screenings.

Hearing, Vision, Dental, Head Lice Check, Scoliosis, Height/Weight, Blood Pressure

Comments: _____

Authorization is given to Avenue City Personnel to consent to medical treatment for my child, _____if we the parents/guardians are not available at the at the time of injury/illness. If our private physician or a consulting physician of his/her choice recommends admission to the hospital, we authorize admission for our child at the time of an injury/illness in our absence. We, the parent/guardians, will be responsible for the charges for any medical treatment or hospitalization rendered by reason on this authorization.

Insurance Company & Policy # _____

If you would like to discuss your child's health concerns with the school nurse, please call 816-662-2305.

_____ _____
Signature of Parent/Guardian Date