USD 204 Student Health Form 2016-17 **(To be completed annually for all students)**

Student name_____ Birthdate_____Grade level_____

Physician _____Phone (____)_____ Dentist _____Phone (____) _____

Health conditions - Please check all that school staff should be aware of. ***Supporting Medical Documentation must be provided.***

- Asthma. Uses inhaler ____yes ____no
  Will inhaler be sent to school? ____yes ____no
- Bone disease/fractures
- Diabetes
- Ear infections (chronic / numerous)
- Emotional disturbances
- Frequent headaches / migraines
- Frequent stomach aches
- Glasses Contact lenses
- Digestive problems
- Heart/blood disease
- Attention deficit disorder
- Kidney disease
- Physical handicap
- Seizure disorder
- Special dietary regimen
- Surgeries
- Throat infections (chronic / numerous)
- Head injuries
- Hearing impairment
  Uses hearing aid ____yes ____no
- My child has no health or medical issues

Allergies - List all known allergies for this student (include medications, foods, insects, environmental, etc.):

_____
_____
_____
_____

A physician has prescribed the use of an Epi-Pen for _____ allergy. _____yes _____no

_____

Please complete this section if your child has been diagnosed with ANY of the items above.

Number of times child has been taken to an emergency room for an episode in the past 12 months:

Describe the type of symptoms your child experiences:

Is there anything that triggers the symptoms?

What usually helps if an episode occurs?

Medications child takes for this condition: Name, dose, frequency:

List any other medications this student takes on a routine basis:

Asthma: Does your child use a peak flow meter? ____yes ____no If yes, what is the child's best peak flow?_____

_____
__

I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. I understand that it is my responsibility to provide emergency medications my child may need. Transportation by ambulance is authorized if required.

I also give consent for immunization information to be released to the Kansas Immunization Program (KIP)

Parent/legal guardian
signature_____Date_____
(Both sides of this form must be completed.) Revised April 8, 2016

USD 204 Over-the-Counter (OTC) Medication Permission Form 2016-17

Student name _____ Grade level
_____

Permission for the administration of <u>over-the-counter medications</u> during school attendance.

I give my permission for authorized school personnel to administer over-the-counter medications/treatments to the above named student for minor discomforts and injuries. I understand that these medications will NOT be given for a fever.

The medications listed below are typically kept in stock and may be given to your student during school hours with parental permission indicated by parent signature below.

- Sore throat/mouth products (cough drops, throat spray, oral pain relief)
- Acetaminophen (equivalent for Tylenol)
- Ibuprofen* (Advil, Motrin or equivalent)
- Antibiotic ointments and/or antiseptic cleaners
- Skin soothing agents (anti-itch creams, lotion, Vaseline, burn ointment)
- Eye drops or eye wash
- Antacids (Tums or generic equivalent)
- Diphenhydramine (Benadryl FOR ACUTE ALLERGIC REACTIONS ONLY)

Students will have access to the medications listed above as deemed necessary by the nurse. There are limited supplies of these OTC medications purchased by the district.

I understand that any school employee who administers any of the above medications, in accordance with the prescription and/or over the counter directions, to my student shall not be liable for damages as a result of an adverse reaction suffered by the student due to this administration. **I further acknowledge that the above student has taken the medication(s) previously (or the initial dosage) and has experienced no adverse reactions.**

_____I give consent for Over the Counter medication to be administered to my child

_____I DO NOT give consent for Over the Counter medication to be administered to my child

Parent/legal guardian
Signature_____Date_____

Revised April 8, 2016