Mid-Buchanan R-V Health Form

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Initial & Date **Initial & Date** **Initial & Date** **Initial & Date** **Initial & Date**

Student's Name: ____ Date of Birth: ____________________

Gender: _____ Male _______ Female Grade: __________

Address: _________________________ City: ________________ Zip: __________ Phone: _______________

Mother's Name: _______________________ Phone: ____________________ Cell Number: ______________

Place of Employment: _____________________________ Work Number: _____________________________

Father's Name: ________________________ Phone: ___________________ Cell Number: ______________

Place of Employment: ______________________________ Work Number: ___________________________

List names of siblings in the school and their grade level if known:

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Emergency Contacts:

Name: ___________________________ Phone: ___________________ Relationship: __________________

Name: ___________________________ Phone: ____________________ Relationship: __________________

List any Medical Allergies: ____

List any Food Allergies: ____

Medical Conditions and Medications:

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PLEASE FILL OUT THE BACK SIDE OF THIS FORM

Please initial items below.

______I give my permission for my child, _________________________________, to receive acetaminophen (Tylenol or other equivalent generic brand) and other over the counter medications for any of the following reasons:

a) Temperature of 100 degrees or greater
b) Headache
c) Toothache or any type of orthodontic work
d) Minor aches/pains (including stomach aches)
e) Menstrual cramps
f) Cough, cold symptoms, sore throat, or earaches related to the common cold
g) Minor cuts and abrasions
h) Rashes (Examples: insect bites, poison ivy, etc.)

YES NO PLEASE CALL PARENT BEFORE GIVING MEDICATION

The school nurse (or health aide in the case of the school nurse's absence) will assess the situation and dispense the medication when appropriate. The proper dose will be determined according to the manufacturer's recommended dosing guidelines. For grades Pre-K through 6th grade, the parent will be informed **by note or phone call** as to why the medication was given and time the medication was given.

_____In case of emergency, I give permission for my child to be taken to the nearest hospital. I do hereby authorize officials of Mid-Buchanan R-V District to contact the persons named on this form that they may authorize treatment as may be deemed necessary in an emergency, for the health of the child. **In the event**, parents and emergency contacts cannot be contacted, after reasonable effort, the school officials are authorized to take whatever action is deemed necessary in their judgement, for the health of the child. **I will not hold the school district financially responsible for the emergency care and/or transportation for my child.**

_____ I understand that it is my responsibility, as a parent, to notify the school nurse if there is any change in the medical status of my child and that the school will rely upon the information I have given during the time my child attends Mid-Buchanan R-V Schools.

______ **I hereby authorize** any physician to release medical information to the Mid-Buchanan school nurse with presentation or copy of this release.

Parent Signature: _____________________________________ Date: ___________________________