Student Health History & Emergency Medical Treatment Consent Form

Student Name _____ **Grade** _____ **Teacher** _____ **Date** _____

Address _____ **Age** _____ **Birthdate**_____ **Gender**_____

Parent/Guardian_____ **Phone** _____

Student's doctor/healthcare provider: _____ **Phone:** _____ **Insurance Provider:** _____

Indicate if student has been diagnosed by a licensed healthcare provider with any of the following and specify type and treatment

	Yes	No					
Does your child have any health issues	☐	☐	****** If Yes you MUST provide physician documentation/medication to your School Nurse******				
Vaccinations up to date	☐	☐	Covid Vaccine Date _____				
Medication Allergies	☐	☐	List medication allergies:				
Food Allergies	☐	☐	Food(s):	Peanut	Dairy	Eggs	Shellfish
Other food allergies please list:							
Allergy to Insects (bees)	☐	☐	Rate the reaction:	mild	moderate	life-threatening	
Allergies (other)	☐	☐	Please list:				
			Reaction	mild	moderate	life-threatening	
Do you have an EpiPen?	☐	☐	**If so you must provide an EpiPen to use at school.**				
Asthma	☐	☐	Rate the severity:	mild	moderate	life-threatening	
Asthma medication taken at home:			Please list Asthma medication required at school: _____				
Do you have an Inhaler?	☐	☐	**If so you must provide the inhaler for student use at school.**				
Skin Disorder	☐	☐					
Adrenal Insuffiency	☐	☐					
Diabetes	☐	☐	Type 1	Type 2	Insulin Resistance	Other	
Diabetes meds list to be administered at School: _____			At home: _____				
Neurological Disorder	☐	☐					
Migraine Headaches	☐	☐					
Seizure Disorder	☐	☐	Type:	Medications:	Triggers:		
Concussion/Head Injury	☐	☐	Date/'s	Special Instructions:			
Hypertension (high blood pressure)	☐	☐					
Heart Condition /Cardiac	☐	☐					
Blood Disorder	☐	☐					
ADD	☐	☐	Medication:				
Mental Health/Behavioral Issues	☐	☐					
Cancer	☐	☐					
Cerebral Palsy	☐	☐					
Cystic Fibrosis	☐	☐	Medication:				
Bladder/Kidney Problems	☐	☐					
Stomach Problems	☐	☐					
Bowel Problems	☐	☐					
Gastric Reflux	☐	☐					
Vision Concerns	☐	☐	Glasses:	Contacts:			
Hearing Concerns	☐	☐	Specify:	hearing aid(s)/device :			
Other Serious Illness	☐	☐		Date of Onset:			
Serious Injury	☐	☐		Date(s):			
Surgery	☐	☐		Date(s):			

Please provide a complete list of your student's medication here both prescribed and over the counter taken daily:

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment and any necessary emergency treatment. I consent for medical photographs to be taken of my student for documentation/treatment purposes. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstances.

Parent/Guardian Signature:_____ **Printed Name**: _____ **Date**:_____