HEALTH CARD (please answer all questions) **SCHOOL YEAR**: _____

Name: _____ M □ F **Teacher**: _____**Grade**: ___
(Last) (First) (MI)

Date of Birth: _____ **Medicaid or AR Kids #:** _____

Address:_____

Parent/Guardian Name(s): _____ Phone Number: _____

Father's Employer: _____**Phone**: _____ **Cell #**: _____

Mother's Employer: _____ **Phone**: _____ **Cell #**: _____

Authorized Emergency Contact: _____**Phone**: _____ **Relationship**: _____
Authorized Emergency Contact: _____**Phone**: _____ **Relationship**: _____

Physician's Name: _____**Phone**: _____

Do you have health insurance? YES□NO **Does your child ride a bus?** YES□NO

Does student have a ***current*** medical diagnosis of any of the following conditions? **Check all that apply**

□ASTHMA	ADD/ADHD	WEAR CONTACTS/GLASSES
□DIABETES	BLOOD DISORDER	HEARING LOSS: RIGHT/LEFT
□HEART CONDITION	CEREBRAL PALSY	□HEARING AID(S)
SEIZURES	KIDNEY DISORDER	OTHER (specify):_____

What medication(s) is your child currently taking?_____

I acknowledge that the Eureka Springs School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

I will notify the school of any change in address, phone number, emergency contact or my child's health status. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

In compliance with the Family Education Rights and Privacy Act (FERPA) (20U.S.C. & 1232g; 34 CFR Part 99), I give permission for my child's personally identifiable information/student education records to be disclosed to ISEP for the purpose of billing Medicaid and/or private insurance.

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.

Date: _____ Signature of Parent/Guardian: _____

Permission to Administer OTC Medication

STUDENT NAME _____ Grade_____
(please print)

Oral medications will NOT be administered prior to 12:00 noon unless otherwise deemed necessary by school nurse

PERMISSION TO GIVE TYLENOL(acetaminophen)
_____**YES**, my child may be given an age-appropriate dose of **TYLENOL** at school.

_____**NO**, my child may not be given **TYLENOL** at school.

PERMISSION TO GIVE MOTRIN(ibuprofen)
_____**YES**, my child may be given an age-appropriate dose of **MOTRIN** at school.

_____**NO**, my child may not be given **MOTRIN** at school.

PERMISSION TO GIVE BENADRYL (diphenhydramine)
_____**YES**, my child may be given an age-appropriate dose of **BENADRYL** at school.

_____**NO**, my child may not be given **BENADRYL** at school.

Occasionally the following items are used to treat superficial injuries/illness for a child. Please initial your **OK** allowing the use of the following items: ___Neosporin ___1%Hydrocortisone cream ___Tums ___Cough Drops ___Orajel ___Pepto

MY CHILD IS HAS A SEVERE OR LIFE-THREATENING ALLERGY TO:

NUTS, LATEX, OR STINGS (specify) _____

MY CHILD IS ALLERGIC TO THE FOLLOWING:

Medications:_____

Foods:_____

MY CHILD HAS THE FOLLOW MEDICAL DIAGNOSIS:_____

_____

X_____

Signature Relationship to Student Date

I CAN BE REACHED AT THE FOLLOWING NUMBER(S) DURING SCHOOL HOURS:

Home_____Work_____ Cell_____