Perry County School District #32

Annual Health Office Emergency Form

Mandatory Completion

Must be Completed by Parent/Guardian

First_____ Middle_____ Last_____ Grade_____

Birth Date_____ M/F_____ ***Please submit any new immunizations to the health office.***

* A physical is recommended- However, students must have one if playing sports- please contact coach

HISTORY/MEDICAL DIAGNOSES - CHECK THOSE THAT APPLY AND SPECIFY ON LINES PROVIDED

☐Asthma ☐Diabetes ☐ADHD/ADD ☐Autism ☐Seizure Disorder

☐Emotional/Behavioral_____ ☐Hearing/Vision Deficits_____

☐Heart/Lung _____

☐Allergies- Specify Food/Other: _____

* Submit Medical Statement for Student Requiring **Special Meals Form** for omissions/substitutions

☐Other History/Medical Diagnoses_____

* Medical diagnoses which impact your child's health/safety during the school day and/or require accommodations will need additional **care plans** - contact the Special Services Office - ext 352

Will your child take any **prescription** medications **at school**? **Yes**_____ **No**_____

* Any medication administered at school (including SELF administered/carry) requires additional completion of **district forms** with written authorization from parent and physician for prescription medications.

Do you permit the nurse/trained staff to administer any **over the counter** medications (examples: Tylenol, Ibuprofen, Zyrtec etc.) for minor healthcare needs according to bottle instructions? **Yes**_____ **No**_____

*If YES but you do not permit a **certain** OTC medication or your child is **allergic** to any OTC medication please list it/them here: _____

*If NO your child will not receive over the counter medications for minor healthcare needs while at school.

NOTICE OF AGREEMENT - To ensure safe care of my child, pertinent health information may be shared with appropriate school staff on a need to know basis. I agree to alert the school nurse of any change in medication or health status/concerns of my child. I understand that basic first aid, with over the counter supplies (bandaids, triple antibiotic ointment), will be used to treat minor issues and provide a prompt return to class. Emergency care will be provided as needed by school staff.

I acknowledge that the above information is true and correct.

Signature of Parent/Guardian: _____ Date:_____

EMERGENCY CONTACTS/ALLOWED TO LEAVE

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

*** Please request additional indicated forms if needed ***