EASTON VALLEY COMMUNITY SCHOOL
CONFIDENTIAL STUDENT HEALTH INFORMATION

Student Name:________________________________ Birthdate: _____________ Grade: ________ Sex: _____

Home Address:____ Home phone#: ____________________

Student lives with: __________________ # of siblings: _____ Ages of Brothers: ________ Ages of Sisters:________

Mother's Name/Address:__________________________________ cell/home phone:______________________
Mother's Employer___________________________ Hrs worked ____ to ____ Phone____________________

Father's Name/Address:__________________________________ cell/home phone: _____________________
Father's Employer___________________________ Hrs worked ____ to ____ Phone____________________

Guardian's Name: ______________________________________ cell/home phone:______________________

Can we contact you by email? Yes or No Email Address____

In case of emergency, the school will attempt to contact parent/guardian before calling a student's primary care provider (Physician). If medically necessary, your child will be transported by ambulance to an emergency care facility.
I request my child be taken to ___________________________________ Hospital in case of medical emergency.

Name(s) of designated adult(s) who will assume responsibility and/or transportation if parent in unavailable.

Name:_____________________________ Relationship:_________________ Phone #: _________________

Name:_____________________________ Relationship:_________________ Phone #: _________________

Health Insurance Coverage: ____ Yes. Company: ____
____ No.
____ I would like information/assistance on finding low-cost health and/or dental insurance.

Family Physician/Clinic, City, Phone #: ____

Family Dentist/Clinic, City, Phone #:____

Specialist(s), City:____

<u>CONFIDENTIAL HEALTH INFORMATION AND COMMUNICATION RELEASE</u>

I give my permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to the above named medical professionals to exchange information for the purpose of referral, diagnosis, and treatment with the Easton Valley Community School Nurse. I give specific permission to my health care provider to share any pertinent health information in my child's health record regarding: Immunizations, Administration of Medications and/or Educationally Significant Health Information that may affect my child's learning and or safety at school.

PARENT/GUARDIAN SIGNATURE: ____ DATE: __________________

Please fill out both sides ⟶

Has your child had the following health interventions <u>within the past 12 months</u>?

Examinations	Doctor	Date	Results
Dental check up			
Eye/Vision Exam			
Ear/Hearing Exam			
Physical Exam			
Injuries / Operations			

Additional Immunizations received/ Date: ____________________

PLEASE CHECK ALL THAT APPLIES TO YOUR CHILD:

[ ] Allergies (medications, food, bee stings, dust/pollen, etc.) List:____________________
Treatment Procedure to be done at school: ____________________

[ ] Heart Condition   [ ] Diabetes   [ ] Asthma   [ ] Seizure Disorder   [ ] ADD/ADHD
[ ] Migraines   [ ] Depression   [ ] Anxiety   [ ] Bladder Issues   [ ] Bowel Issues
[ ] Hearing Problems   Left ear_________   Right ear_________   Hearing Aid(s) _________
[ ] Vision Problems   Wears glasses ____________   Contact lenses ____________

DOES THE STUDENT:

1. Receive any Medication at home or in school?   NO OR YES   REASON:____________________
   Medication/ Dosage: ____________________ Time Taken: ____________________

A MEDICATION PERMISSION FORM must be completed before any prescription or over the counter medication is given at school. The medication must also be in its original labeled container. Prescription medication bottles must contain a current pharmacy label.

2. Have history of having Chicken Pox Disease or Vaccine?   NO OR YES   WHEN? ____________________

3. Have history of Illness, Surgeries, Accidents or Events that could affect his/her learning ability in school?   NO OR YES
   Explain: ____________________

4. Have history of Serious Illness in immediate family that could affect his/her learning ability in school?   NO OR YES
   Explain: ____________________

Other information or instructions: ____________________

<u>AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION AT SCHOOL</u>

Any medication, including Acetaminophen or any over the counter medication, requires written parent authorization. A supply of regular and junior strength Acetaminophen and non-medicated menthol cough drops is available through the health office for occasional and emergency use. Students requiring more frequent administration of these medications are asked to bring their own personal supply in its original bottle to be kept in the school office.

_________ YES, I give permission for my child to be given Acetaminophen and/or cough drops at school according to dosage guidelines on product label.

_________ NO, I do not want my child to be given Acetaminophen and/or cough drops at school.

PARENT/GUARDIAN SIGNATURE: ____________________ DATE: ____________________