SOUTH CENTRAL SCHOOLS YEARLY HEALTH INFORMATION

Name of student:______________________________________ D.O.B________________ Grade: _____

Doctor:____ Phone: __________________________

Dentist:____ Phone:__________________________

HEALTH HISTORY	YES	NO	COMMENTS
Medication (All medication given at school must have a consent form completed each year and on file at the school-includes prescription and over-the-counter medications and inhalers.)			
Allergies (Food, Drug, Insect, ect.) If your child has a food allergy, this state form must be completed by the physician to receive accommodations.			
Epipen Needed?			
Diagnosed with Asthma? (Needs asthma action plan)			
Inhaler at school?			
Diabetes?			
Head injury/Concussion/Passed out?			
Seizures? (need seizure action plan)			What are they like?
Heart problems? Blood Pressure issues?			
Eye/Vision Problems?			**Glasses?____ Contact?____** **Date of last eye exam? ________**
Ear/Hearing Problems?			**Issues?** **Last hearing evaluation?**
Bone/joint problems?			
Hospitalizations? When? What for?			
Surgery? When? What for?			
Other medical problems or Concerns?			

- I hereby authorize the superintendent or his designee to contact my child's physician regarding my child for the purpose of providing information and/or medically needed treatment for my child's wellbeing.
- I hereby authorize South Central School to disclose my child's health information to teachers, substitute teachers, and cafeteria st at the school or at school events including field trips to the extent necessary to protect my child.
- If I cannot be reached in an emergency (in the judgement of the staff and chaperones) and immediate medical treatment is necessary, I authorize the responsible adults to send my child (accompanied) to an available hospital or physician.

Permission for Over-the -Counter Medication: I would like the following medication(s) made available to my child *(please check which ones you give permission for):*

____ Cough drops ____Antibiotic Ointment ____ Hydrocortisone ____ Antifungal cream ____ Orajel ____Calamine Lotion

I, parent/guardian give permission for the above named child to receive any medication listed and checked above as deemed necessary by school personnel. I understand that generic equivalent medications may be used. I understand that the medications I have checked will be administered in accordance with established standings orders

_____ I **do not give permission** for over-the-counter medication to be given at school.

Parent/Guardian Signature______________________________________ Date: ____________________