**RUSSELLVILLE STUDENT MEDICAL INFORMATION FORM**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_ Student’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid/ARKids 1st #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Parent or Legal Guardian to contact in case of illness or emergency:** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local emergency contact if Parent or Guardian cannot be reached: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Physician / Dentist Information:** Student’s primary care physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s medical specialist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s eye doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has the student ever been seen by a dentist? \_\_\_\_\_ Student’s dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **My child has the following diagnosis(es):**

\_\_\_Allergies (Food, Environmental, Seasonal, Medication, etc) \*Does the student have an Epipen? \_\_\_\_yes \_\_\_\_no

\_\_\_Arthritis (Rheumatoid)

\_\_\_ADD/ADHD

\_\_\_Asthma Does the student have an inhaler? \_\_\_\_yes \_\_\_\_no

\_\_\_Behavioral/Psychological/Developmental problems

\_\_\_Dental Problems

\_\_\_Diabetes Type 1\_\_\_\_ Type 2\_\_\_\_ \*Does the student take insulin? \_\_\_\_yes \_\_\_\_no

\_\_\_GERD (acid reflux)

\_\_\_Frequent Headaches/Migraines

\_\_\_ Head or Spinal Injury

\_\_\_Heart Disease

\_\_\_Kidney Disease

\_\_\_Seizures \*Does the student have an emergency seizure medication? \_\_\_\_yes \_\_\_\_no

\_\_\_Spina Bifida

\_\_\_Hearing Impairment or Hearing aides

\_\_\_ Visual Impairment/glasses/contacts

\_\_\_OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*If you checked any of the above health conditions, please explain:\_\_\_\_\_\_\_\_\_ \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list **all** medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe any other important health-related information about your child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please list any health conditions that the student had in the past that are no longer a problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Please indicate by writing your initials if you approve or decline the following over-the-counter stock medications to be administered to your child at school:**

Benadryl (liquid): Approve\_\_\_\_\_\_ Decline\_\_\_\_\_\_

Sunscreen: Approve\_\_\_\_\_\_ Decline\_\_\_\_\_\_

Topical creams (Hydrocortisone, Neosporin, etc): Approve\_\_\_\_\_\_ Decline\_\_\_\_\_\_

**\*\*Please indicate by writing your initials if you approve or decline the following screenings:**

 Vision: Approve \_\_\_\_\_ Decline\_\_\_\_\_ Scoliosis: Approve\_\_\_\_\_ Decline\_\_\_\_\_

 Hearing: Approve \_\_\_\_\_ Decline\_\_\_\_\_ BMI: Approve\_\_\_\_\_ Decline\_\_\_\_\_

**I have provided all medical, behavioral, and legal information necessary for staff to understand my child’s needs and to provide safety for my child and others, including emergency contacts information. I give my permission for the school nurse to contact my child’s physician(s) and/or teacher(s) to discuss needed information contained on this form. PRINTED NAME OF PARENT OR LEGAL GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF PARENT OR LEGAL GUARDIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_**