MEDICAL INFORMATION AND CONSENT FORM

STUDENT NAME:_____ **DOB**_____ **M/F**
M/D/Y

CONSENT FOR OVER-THE-COUNTER MEDICATION: All medication brought to school must be in the original container. The school will use generic antibiotic ointment, orajel, cough drops and anti-itch lotion with parent/guardian consent as needed. Acetaminophen or Ibuprofen for fever >101 or minor headache will be given with parent/guardian consent. USD289 will not be liable for any adverse results of medication administered when given in accordance with the above statement.
I have read and agreed with the above: **PARENT/GUARDIAN INITIALS,**_____

MEDICAL INFORMATION: Please list any information that applies to your child

ALLERGIES/TREATMENT FOR:_____

ASTHMA/LUNG DISORDERS_____

HEART CONDITIONS:_____

NEUROLOGICAL/SEIZURES/HYPERACTIVITY:_____

INTESTINAL/BLADDER DISORDERS_____

VISION/HEARING/EAR PROBLEMS_____

SKIN CONDITIONS_____

ENDOCRINE/DIABETES_____
DAILY MEDICATIONS_____

In the last year has your child seen an optometrist Y N or a dentist? Y N
In case of emergency and after all efforts have been made to contact parents/guardian, I give USD 289 permission to seek medical care for my child. I give USD 289 permission to share health information/immunizations/health records with other health professionals as needed.

I GIVE MY CONSENT FOR INFORMATION OF MY CHILD'S IMMUNIZATIONS BE RELEASED TO THE KANSAS IMMUNIZATION PROGRAM FOR THE PURPOSE OF ASSESSEMENT AND REPORTING

YES

NO

SIGNED:_____
RELATIONSHIP_____

DATE:_____