MAGNOLIA SCHOOL DISTRICT
Magnolia, Arkansas 71753

HEALTH HISTORY & EMERGENCY MEDICAL CARE PERMISSION 2018-2019

STUDENT _____ **DATE OF BIRTH** _____ **TODAY'S DATE** _____

PARENT/GUARDIAN _____ **GRADE** _____

ADDRESS _____

PHONE: Primary _____ **Parent's Work** _____ **Parent's Work** _____
Other _____ **Cell** _____ **Cell** _____

HEALTH DIAGNOSIS check any that apply:

ADD/ADHD _____ **Heart Disease** _____ **Diabetes** _____

Kidney Disease _____ **if yes, please specify** _____

Sickle Cell Disease _____ **Sickle Cell Trait** _____

Glasses _____ **Hearing Aides** _____

Asthma_____
If yes, does your child require an inhaler at school? _____
Seizures _____
If yes, does your child take medication for seizures? _____
When was your child's last seizure? _____
Does your child require emergency medications (ex. Diastat) to be kept at school for seizures? _____

ALLERGIES list known allergies of each category:

No known allergies _____
Seasonal Allergies_____
Food Allergies (<u>if a special diet is required, a dietary needs and food allergy form must be completed by physician</u>)
_____
_____

Drug Allergies _____
Other Allergies: BEE_____ **FIRE ANT**_____
WASP_____ **OTHER INSECT** _____

If you checked any of the above:
***What type of reaction has your child had in the past?**
_____
***Does your child require Benadryl at school?** _____
***Does your child require an Epipen at school?** _____

MEDICATIONS: CONSENT FORM MUST BE COMPLETED FOR MEDICATIONS AT SCHOOL:

Home Meds and dosages: _____
_____

School Medications and dosages_____
_____

******Parent must bring medication to school to the nurse. Students are <u>not</u> allowed to transport <u>any</u> medications to school******

BEHAVIORAL/MENTAL/EMOTIONAL CONCERNS:

Diagnosis_____
_____
_____
_____

Therapist/Counselor _____

I authorize this information to be shared with school staff – teachers, administrators, bus drivers, when deemed necessary. I also authorize sharing of above information with E.M.T.'s and other emergency care personnel in case of emergency.

In the case of an emergency allergic reaction, I authorize the school nurse to administer auto-injector epinephrine to my student if the school nurse in good faith professionally believes the student is having an anaphylactic reaction.

In case of sudden illness or accident requiring more attention than normal first aid, if I cannot be contacted, take my child to Doctor _____ or Doctor _____.
(local physician) (local physician)

In case of extreme emergency, I authorize the school to call emergency medical services for transportation to the hospital.

As parent/guardian of this student, I am responsible for obtaining and returning medical forms with any health problems listed above and provide necessary medication needed at school to the nurse.
<u>I will notify the school office immediately if any of the above information changes.</u>

_____ _____
SIGNATURE - PARENT/GUARDIAN **DATE**

Revised 2-2018