Smackover School District

Medical Information Release

Student's Name: _____ SS#_____Date of Birth _____ Grade_____
Mailing Address_____**911Address**_____
Mother's Name_____**Cell Number:** _____**Work Number**_____
Father's Name _____**Cell number:**_____**Work Number**_____

HEALTH QUESTIONAIRE: CHECK CONDITIONS THAT APPLY TO YOUR CHILD

___ADD/ADHD	___Cardiac problem	___Headaches	___Orthopedic Problem	___Anxiety/Panic Attack
___Cerebral palsy	___Hearing Problems	___Scoliosis	___Asthma	___Diabetes
___Kidney/Urinary Problem	___Seizures	___Bee Allergy	___ Epi-Pen	___Lung Condition
___Spina Bifida	___Behavior Problem	___Food Allergy	___Muscle Disorder	___Vision Problem
___Bowel Problem	___Emotional concerns	___Neurological Problem		___Other (Explain)

If any of the above were check please describe: _____

_____

_____

Please **circle** - **YES** or **NO** on the following questions;

Does your child wear **GLASSES**? **YES or NO** Does your child wear C**ONTACT LENSES**? **YES or NO**

Does your child have **ALLERGIES TO ANY MEDICATION**? **YES or NO**
If yes please list: _____

Does your child have any **ENVIRONMENTAL ALLERGIES? YES or NO**
If yes please list: _____

Is your child on any **MEDICATION** we need to be aware of? **YES or NO** If yes please list: _____
_____

Does your child have **HEALTH INSURANCE**? **YES or NO** (If yes please complete below):
Name of Insurer or Policy Holder's name_____
Name of Insurance_____Address_____
Contact phone number: _____Group #_____ID#_____

Family Doctor's name: _____Address:_____Phone Number_____

Does your child have **ARKIDS 1ST**? **YES or NO** If yes please complete---ARKIDS 1st number on card_____

Child living with whom:
Father_____ Mother_____ Stepfather_____ Stepmother_____ Grandparents _____Guardian_____

List brothers and sisters living in same household:

Name	Grade	Name	Grade
_____		_____	
_____		_____	
_____		_____	

RELEASE OF INFORMATION: I, the parent or legal guardian, give permission for this information to be shared with school staff or emergency medical personnel on a "NEED TO KNOW BASIS" during the 2013-2014 School year.

AUTHORIZATION FOR EMERGENCY MEDICAL CARE
I Herby authorize the school to obtain emergency medical care for my child named at the top of the page, if needed, and if we (the parents/guardians cannot be reached.

Parent or guardian Signature_____ **Date**_____