MORA INDEPENDENT SCHOOL DISTRICT

Student Health History & Emergency Medical Treatment Consent Form

School Year ______________

Student		**School**	**Grade/Teacher**
Address		**Birth Date**	**Gender**
Parent/Guardian/Emergency Contacts	**Relationship**	☎ **Phone**	
Call 1st:		Home: Work:	Cell:
Call 2nd:		Home: Work:	Cell:
Call 3rd:		Home:	Cell:
		Work:	

Student's doctor/healthcare provider: ____ **Phone:** ________________

Insurance Information: ____

(Include Group's Name, ID Number, Group Number, and Subscriber)

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

If your child has a life-threatening condition, state law requires that medication and/or treatment orders from your licensed healthcare provider, and an Emergency Plan prepared by the School Nurse, must be in place before your child can attend school.

Health Condition	Yes	No	Explanation if "Yes"
Medication Allergies	☐	☐	**List:**
Food Allergies	☐	☐	**Food(s):** ☐ **peanut** ☐ **dairy** ☐**eggs** ☐**other** ______________________________ **Rate the reaction:** ☐mild ☐moderate ☐ life-threatening **Does your child require an EpiPen?** ☐yes ☐no
Allergy to Bees Stings	☐	☐	**Rate the reaction:** ☐mild ☐moderate ☐ life-threatening **Does your child require an EpiPen?** ☐yes ☐no
Allergies (other)	☐	☐	**List:**
Asthma	☐	☐	**Rate the severity:** ☐mild ☐moderate ☐ life-threatening **Asthma medication taken at home:** **Medication required at school:**
Diabetes	☐	☐	☐**Type 1** (Insulin Dependent) ☐**Type 2** **Diabetes medication(s) taken at home:**
Seizure Disorder	☐	☐	**Type of Seizure:** **Medications:**__________________________________
Neurological Disorder	☐	☐	**Specify:**
Heart Condition	☐	☐	**Specify:**
Blood Disorder	☐	☐	**Specify:** **Treatment:**
Cancer	☐	☐	**Specify:** **Treatment:**
Bowel/Bladder Issues	☐	☐	**Specify:**
Migraine Headaches	☐	☐	**Triggers:** **Treatment:**

Bone/Muscle Problems	☐	☐	**Specify:** **Activity Restrictions:**
ADD/ADHD	☐	☐	**Medication for ADD/ADHD:**
Mental Health Behavioral Issues	☐	☐	**Specify:** **Treatment/Medication:**
Wears Glasses/Contacts	☐	☐	**☐Glasses ☐Contacts → ☐For Distance ☐For Reading**
Hearing Loss	☐	☐	**☐Hearing Loss Right Ear ☐Hearing Loss Left Ear ☐Hearing Aid(s)**
Other Serious Illness	☐	☐	**Specify:** **Date of Onset:**
Serious Injury	☐	☐	**Specify:** **Date(s):**
Surgery	☐	☐	**Specify:** **Date(s):**
Medication Taken at Home *(if not already listed)*	**List:**		

The information on this form may be shared confidentially with school staff and emergency responders as needed. In the event of a medical emergency with my child, I understand every effort will be made to inform me. If emergency care is needed, I authorize qualified professionals to provide assessment, diagnosis and any necessary emergency treatment. I understand that the school district assumes no financial liability for expenses incurred due to accident, injury and/or unforeseen circumstance.

_____________________________________ ________________________________ __________

PARENT/GUARDIAN SIGNATURE *PRINTED NAME*

Reviewed by School Nurse: ……………………………………..