Perry County School District #32
Annual Health Office Emergency Form
(to be completed by parent/guardian)

First______________________ Middle ____________________ Last ______________________
Grade_____________________Birth Date__________________ Male/Female (please circle one)

All students new to the district must submit a physical that is dated within one year of the date of enrollment.

Please submit any new immunizations to the health office.

Dentist's Name : ________________________ Phone: _________________ Last Visit: __________
Doctor's Name:__________________________Phone:__________________Last Visit: ___________
Eye Doctor :____________________________ Phone: __________________Last Visit: __________

HISTORY/MEDICAL DIAGNOSES -PLEASE CHECK ANY THAT APPLY

☐Asthma ☐Diabetes ☐ADHD ☐Autism ☐Seizure Disorder

☐Heart/lung(specify)______________________________

☐Allergies (specify) food:____

☐Other Allergies (specify): ____

☐Hearing Deficits ___________________________ ☐Vision Deficits ____________________

☐Emotional/behavioral health ____

☐Other Health Concerns____

Medical diagnoses that impact your child's health and safety during the school day and/or require treatment or accommodations, such as severe food allergies, will need additional health care plans. Please contact your school nurse to complete this information. For any dietary restrictions requiring food substitutions, submit Medical Statement for Student Requiring Special Meals.

Please list routine prescription and over the counter medications given at home or school.
Medication _______________ Reason ____________ Dose ________Time ____________
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Will your child take medications at school? Yes ____________ No _____________

Any medication administered at school required additional completion of district forms. With written authorization from parents and the physician. Please contact your school nurse to complete this information.

CONTINUE ON BACK SIDE PLEASE

CONSENT

Parental approval to use supplies in nurses office which allows for efficient treatment of students minor health issues and their prompt return to the classroom setting: skin care lotion, petroleum jelly, any over-the-counter anti-itch cream/lotion/gel, triple antibiotic ointment, over-the-counter antifungal cream, over-the-counter ointment for burns and aloe, carmex ointment, orajel for toothache, sting kill swabs-topical anesthetic for bee/insect stings, any over-the-counter eye drops/contact solution and /or eye wash, hydrogen peroxide, rubbing alcohol, bactine, antacid tablets, nail polish remover, salt water gargle, prid drawing salve, any sunscreen.

Yes ___ No ____ I give my permission for the nurse or trained designee to administer appropriate medications for my child's minor illness, injuries or complaints of discomfort according to the package instructions.

NOTICE OF AGREEMENT

To ensure safe care of my child, I agree that pertinent health information may be shared with appropriate school staff, including transportation employees and cafeteria on a need to know basis. I agree to alert the school nurse of any change in medication or health status of my child. I will furnish the school with current phone numbers and address in case of an emergency. The school nurse may contact the health care provider regarding any health concerns pertaining to students.

I understand that basic first aid and emergency care will be provided as needed by school staff.

I acknowledge that the foregoing above information is true and correct.

Signature of Parent/Guardian: ______________________________ Date: _____________________________

EMERGENCY CONTACTS

Mother's Name ________________________Best Contact Number____________________

Father's Name ________________________ Best Contact Number ___________________

Please List 2 Other Emergency Contacts For Health Office

Name ___________________________ Number _____________ Relationship __________

Name ___________________________ Number _____________ Relationship __________