POCAHONTAS PUBLIC SCHOOLS CONFIDENTIAL HEALTH RECORD

Name: _____ Grade: _____ DOB_____

Bus Rider: (Circle one) Yes No If yes, bus name _____

Mother/Guardian: _____Home Phone: _____

Address: _____Cell Phone: _____

Place of employment: _____Work Phone: _____

Father/Guardian: _____ Home Phone:_____

Address: _____Cell Phone:_____

Place of employment: _____ Work Phone:_____

With whom does your child live?_____

Names and ages of other children living in the home:_____

If parents cannot be reached, in the case of an emergency, call:

Name:_____Phone:_____ relationship:_____

Name:_____Phone:_____relationship:_____

Doctor _____Phone or clinic name:_____

I give the school nurse permission to contact my child's physician if needed (Circle one) Yes No

PLEASE CIRCLE THE FOLLOWING OVER THE COUNTER MEDICATIONS THE NURSE HAS PERMISSION TO ADMINISTER TO YOUR CHILD IF NEEDED:

Tylenol (Acetaminophen) Tums Ibuprofen Throat spray OraJel

Does your child have any medical conditions? If yes, please list below:

Condition_____Medication_____

Do they have an allergy to food, insects, latex, if so what_____

Do they have an Epi-pen for above allergy? Yes No (If you circled yes you will need to provide the nurse with one to keep in the nurse's office)

Do they have asthma that requires an inhaler? Yes No (If you circled yes are they capable of carrying the inhaler with them and self- administering) Yes No (If you circled no then you will need to provide the nurse with one to keep in the nurse's office)

I understand that the above information may be released to **ALL** appropriate Pocahontas School employees and emergency personnel in order to facilitate health care.

Parent Signature: _____Date:_____