

VALLIANT PUBLIC SCHOOLS NURSE ALERT FORM

In order to provide a safe and healthy environment for your child, this information will be reviewed by the school nurse and shared with the staff. Minor health conditions that will not affect your child at school do not need to be listed on this form.

Student Name: _____ Birth Date: _____

Building: _____ Grade/Teacher: _____

SERIOUS HEALTH CONDITIONS

If your child has a serious medical condition, it is vital that you discuss this with the school nurse immediately. Oklahoma State Law requires that medication or treatment orders, medications and a health care plan be in place prior to the start of school.

_____ **My child does not have any health conditions that will affect him/her at school.** (If this is checked no further information is necessary. Sign and date below.)

_____ **My child has the following serious health conditions:**

_____ **Asthma - will your child require an inhaler at school?** **yes** **no**

_____ **Cardiac Diagnosis:** _____

Restrictions: _____

_____ **Diabetes** **Date of diagnosis:** _____

Insulin Pump	Insulin Pen	Insulin Syringe
Independent	Dependent	

_____ **Life Threatening Allergy - requires an EpiPen or Auvi-Q at school**

Allergens: _____

_____ **Seizure Disorder Type:** _____

Medications: _____

_____ **Other serious health conditions:** _____

All medications given at school require an Authorization for Administration of Medication Form, available at the school office. All prescription medications must be in the original container with a pharmacy label that matches the health care providers orders. Over the counter medications and supplements must be in the original container marked with the student's name.

Medications to be given at school: _____

Medications taken at home: _____

I, the undersigned, do hereby authorize the officials of the Valliant School District in the event of an emergency, and the parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent/Guardian Name: _____ Phone Number: _____

Health Care Provider: _____ Phone Number: _____

Signature: _____ Date: _____

EMERGENCY CONSENT TO MEDICAL TREATMENT

Valliant Public School Representative: _____

Relationship to Student: _____

Medical Treatment to be given: _____

Date: _____