WHEELER HIGH SCHOOL
EMERGENCY HEALTH PLAN

Student's Name	School	DOB

HEALTH CONCERNS:

Please check any of the following conditions that pertain to this student:

☐ Glasses/Contact	☐ Vision/Hearing	☐ Seasonal Allergies
☐ ADD/ADHD	☐ Migraines/Frequent Headaches	☐ Arthritis/Bone
☐ Kidney/Bladder	☐ Stomach/Bowel issues	☐ Congenital Defects
☐ Heart Conditions	☐ Physical Handicap: _____	

The following conditions must have an **Emergency Plan Form signed** by a physician and on file with the school Nurse. See the school nurse for this form and if you have any questions.

Allergies: ☐ **Food** (Type) _____ ☐ **Medication** (Type) _____ ☐ **Bee Sting**

☐ *Carries Epipen* ☐ *Epipen – kept in the Nurse's office*

☐ **Asthma** ☐ *Carries Inhaler* ☐ *Inhaler – kept in the Nurse's office*

☐ **Diabetes** ☐ **Seizures** (Type) _____

MEDICATIONS: _____

Any health concerns (not listed above): _____

_____

In case of serious illness/injury, I give permission for the above named student to be treated at the nearest emergency room.

Parent/Guardian Signature	Printed Name of Parent or Guardian	Date

My child has my ***permission to take acetaminophen*** (Tylenol-like) at school. I am authorizing this ONE TIME dose to be given to my child:

☐ 1(one) tablet acetaminophen 325mg ☐ 2 (two) tablets acetaminophen 325mg.

Parent/Guardian Signature	Printed Name of Parent or Guardian	Date

UNION TOWNSHIP SCHOOL CORPORATION

CHILDREN AND HOOSIERS IMMUNIZATION REGISTRY PROGRAM CONSENT (CHIRP)

I; _____, give Union Township Schools permission to release the following
Parent/Guardian

information concerning my child; _____to the Indiana State Department
Student's Name

of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

I GIVE PERMISSION FOR THE FOLLOWING INFORMATION TO BE RELEASED:

- **IMMUNIZATION DATA**
- **IDENTIFYING INFORMATION SUCH AS; NAME, DATE OF BIRTH AND ADDRESS.**
- **LIST ANY ADDITIONAL INFORMATION:**_____

_____

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____	_____	_____
Parent/Guardian Signature	Printed Name of Parent or Guardian	Date
_____	( ) _____	
Address	Telephone Number	
_____	_____	_____
Child's Name	School	DOB