North Fayette Valley Student Health Information Form 2021 -22

Student Information

Last Name_________________________ First Name_______________________ DOB______________Grade______

Parent/Guardian Name________________________________Phone No(s).__________________________________

Parent/Guardian Name________________________________Phone No(s).__________________________________

Local emergency contact in the event neither parent/guardian can be reached:

Name____ Phone No(s).____

Name____ Phone No(s).____

Health and Insurance Information

Primary Health Care Provider _______________________________________ Phone No____________________

Primary Dentist____ Phone No.____________________

Type of Insurance ______None _______ Hawk-I ______Private ______Medicaid

List all medications your child is taking:

At home:____

At school:____

Please check one ________My child does not have any specific health problems at this time **OR**

________ My child has the following health problems *(check all that apply)*

_____Allergy (Please describe)________________ *Is EPI pen needed at school* ____Yes (Parent must supply) _____No

_____Asthma - *Is an Inhaler is needed at school* ______ Yes (Parent must supply) _____ No

_____Diabetes _______ Seizures _______ Bleeding Disorder _____ ADD/ADHD

_____ Heart Condition _____ Skin Condition _______ Bone/Muscle Condition _____ Other____________________

Comments:____

Administration of Over-the-Counter (OTC) Medications

☐ **I give permission** for the school nurse/certified staff to administer to my child, as appropriate and per manufacturer's instruction, the following OTC products as checked. These preparations may be administered throughout the current school year without prior phone call:

☐ Acetaminophen 500 mg ☐ Acetaminophen 325 mg ☐ Ibuprofen ☐ Antacid/Diotame

☐ Children's Chewable Tylenol ☐ Benadryl ☐ Bacitracin ☐ Hydrocortisone

☐ Revive Eye Drops ☐ All OTC Medications Listed

☐ **I do <u>not</u> give permission** to administer the listed OTC medications.

Permission

*I give the emergency contact permission to release my child from school for medical reasons if I cannot be reached

*I give permission to the appropriate personnel of the North Fayette Valley Community School District to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary and in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment .

*I understand that by checking that I give permission to administer OTC medications, that I give permission to designated school personnel to give medication to my student during the school day and I further agree to hold the North Fayette Valley Community School District and employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

*I understand that if my student comes to the health office multiple times with the same complaint, that I may be notified for referral for further evaluation and/or asked to bring personal OTC medication to the health office for administration.

*I verify that the information on this form is correct and understand that it is my responsibility to notify the school whenever there is a change in my child's health status or care. I understand that this information is confidential but the information will be shared with other school personnel as needed.

* My student _____ may/_______ may not participate in routine health screenings (height/weight, vision, etc)

Parent/Guardian Signature:____ **Date:**__________________________