# NORTH UNION COMMUNITY SCHOOL DISTRICT- SWEA CITY CAMPUS

*Health Information & Consent Form*

Student Name:_____ DOB:_____Age:_____
Grade:_____ MALE/FEMALE

**Please provide provider's name, number, and last appointment date:**
Family Doctor:_____
Specialist:_____
Dentist:_____
Eye Doctor:_____

**Please identify any of the following that apply to your child and provide additional details as it pertains on the space provided below (ex: medications/treatments/other specifics/etc):**

- ☐ ADHD/ADD/Behavior Issues
- ☐ Autism/Asperger's
- ☐ Anxiety/Depression
- ☐ Other Mental Health (list below)
- ☐ Headaches/Migraines
- ☐ Glasses/Contacts (circle)
- ☐ Heart Condition
- ☐ Dental/Vision/Hearing Concerns
- ☐ Seizures _____Type_____Last episode
- ☐ Asthma** Inhaler w/_____Nurse_____Student
- ☐ Diabetes** Type 1 or 2 (circle) ___Insulin____ Pump
- ☐ Medication Allergies(list below)
- ☐ Environmental/Seasonal Allergies (list below)
- ☐ Food Allergies/Sensitivity(list below)**
- ☐ No known medical concerns or issues

Please Explain:_____
_____
_____
_____

**Meds Taken At Home**:_____
**Meds Taken At School****:_____

**Please select the medications, if any, that are ok for the school nurse or trained school staff member to administer to your child. All medications are given/used as directed on their package for the intended purpose only.**

- ☐ None
- ☐ Acetaminophen (Tylenol)
- ☐ Cough Drops
- ☐ Midol (menstrual cramps 12 & up)
- ☐ Benadryl
- ☐ Eye Drops (Clear Eyes)
- ☐ Sunblock*
- ☐ Bug Spray*
- ☐ Ibuprofen (Advil/Motrin)
- ☐ Antacid Tablets (Tums)
- ☐ Triple Antibiotic Ointment
- ☐ Hydrocortisone Cream
- ☐ Oral Pain Relief (benzocaine 20%)
- ☐ Biofreeze

**Sunblock/Bug Spray would be limited to outdoor field trips. Will not be applied daily for recess/etc.*

*** Additional forms are required*

PLEASE COMPLETE BOTH SIDES OF THIS FORM

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I give my permission for the school nurse to discuss the information on this form with my child's teacher(s) on a need to know basis. Information is otherwise kept confidential.
***Initials*_____**

I give permission for the school nurse or other trained personnel to perform routine health screenings that may include hearing, vision, dental, height and weight. You will be contacted with abnormal screenings results.
***Initials*_____**

I authorize my child's healthcare provider and the designated provider of healthcare in the school setting to discuss my child's health concerns and/or exchange information pertaining to the form. This authorization will be in effect for this school year, unless you withdraw it. You may withdraw your authorization at any time by contacting the school. When information is released from your child's records, documentation of the disclosure is maintained in your child's health record.
***Initials*_____**

## Emergency Contacts

*Please provide a minimum of 2 emergency contacts in the order they should be contacted*

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Any additional medical information that could be helpful for the school to know inorder for us to keep your child safe and cared for in their learning environment

_____
_____
_____
_____

Please keep the school nurse and staff up to date with any changes in your child's medical history throughout the school year. Thank you.

Parent/Guardian
Signature_____Date_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM