Student Health Registration Form

South Central Calhoun Community Schools

Student Legal Last First Name	Gender	Birthdate	Home Phone	Grade
		/ /	( ) -	
Student Primary Address	City, State, Zip Code		County	School Building

Please contact your school nurse if your student has any health concerns that need to be addressed in the school setting.

Medical History

*Is your child **currently** being treated for any of the following? Please check all that apply.*

	Asthma/Reactive Airway		Seizure Disorder		Bleeding Disorder		ADD/ADHD
	Diabetes		Bone/muscle disease		Skin Condition		Pregnancy
	Heart Condition		Mental health condition(i.e., depression, anxiety, eating disorder)				Other_____

Does your child experience any of the following?

	nose bleeds		frequent earaches		overweight for age		physical disability
	poor appetite		frequent stomachaches		frequent headaches		fainting spells
	tires easily		underweight for age		learning disability		other_____

Allergies

Is your child allergic to anything? ____ ***Yes*** ____ ***NO*** *If yes, please check all that apply.*

	Food (list what types of food)
	Medicine (list what types of medicine)
	Other

Describe what happens when your child has an allergic reaction:

Does your child need an Epi-Pen at school? ____**Yes** ____**No** *If yes, the parent is required to supply school with an Epi-Pen*

Hearing/Vision

Do you have concerns about our child's hearing? ____**Yes** ____**No** Does your child wear hearing aides? ____**Yes** ____**No**

Do you have concerns about your child's vision? ____**Yes** ____**No** Does your child wear glasses or contacts? ____**Yes** ____**No**

Medication

Please list all of your student's medications.

Name of Medication	Time medication is given	Reason for medication

Over-the-counter Medication

Do you want your child to receive over-the-counter medication at school? ____ **Yes** ____ **No***If no, continue to Insurance section*

If yes, please check which medications you want your child to receive:

___**Acetaminophen (Tylenol) and/or** ____**Ibuprofen (Advil, Motrin)**

If your child cannot have Ibuprofen or Tylenol please specify:_____

Parent's Signature: _____ **Date Signed**: _____

A total of 10 doses of over-the-counter medication will be given per year unless there is an order from a physician.

Insurance

Does your child have health insurance? ____**Yes** ____**No***If yes, please check one that applies:*

☐ Private Provider _____ ☐ hawk i ☐ Medicaid # _____

Immunizations: What, if any, immunizations did your child receive in the last year? _____

In case of emergency:

Contact #1: Parent_____ Phone Number (s)_____

Contact #2: Name_____ Phone Number_____ Relationship_____

Emergency Release

I give permission to the appropriate personnel of the South Central Calhoun Community Schools to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary 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 as authorized in this statement. I understand that this health information sheet is confidential but the information will be shared with other South Central Calhoun personnel as needed.

Parent/Guardian Signature: _____ Date Signed: _____