

**SHELBYVILLE CENTRAL SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION PERMIT
HEALTH HISTORY
2010-2011**

TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL CHILDREN ENTERING SHELBYVILLE CENTRAL SCHOOLS. PLEASE COMPLETE AND RETURN AT REGISTRATION.

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care. This authorization is valid for the current school year or until such time as I withdraw the authorization.

AUTHORIZATION _____ DATE _____
(Parent/ Guardian Signature)

STUDENT INFORMATION

CHILD'S NAME _____ SEX _____
(Last) (First) (Middle)

ADDRESS _____ TELEPHONE _____

DATE OF BIRTH _____ ALLERGIES _____

SCHOOL _____ GRADE _____ TEACHER _____

PHYSICIAN NAME _____ TELEPHONE _____

DENTIST NAME _____ TELEPHONE _____

OPTOMETRIST NAME _____ TELEPHONE _____

INSURANCE COMPANY _____ ID NUMBER _____

PARENT/CONTACT INFORMATION: (If not living with both parents, please indicate custody parent by an *. If living with guardian please indicate that also.)

FATHER'S NAME _____ TELEPHONE _____

PLACE OF EMPLOYMENT _____ TELEPHONE _____

MOTHER'S NAME _____ TELEPHONE _____

PLACE OF EMPLOYMENT _____ TELEPHONE _____

EMERGENCY CONTACT #1 _____ TELEPHONE _____

EMERGENCY CONTACT #2 _____ TELEPHONE _____

FAMILY INFORMATION: Please list names of other children living with you.

| <u>First</u> | <u>Middle</u> | <u>Last</u> | <u>Date of Birth</u> | <u>Relationship</u> |
|--------------|---------------|-------------|----------------------|---------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Names of others living in household: _____

HEALTH HISTORY

Student Name _____ Date of Birth _____ GRADE _____

PART I: Student Health Status

Complete the following checklist by indicating any of the following conditions, past or present and give approximate dates.

| | Yes | No | Date | | Yes | No | Date |
|-------------------------------|-----|----|------|----------------------|-----|----|------|
| Activity Restriction | | | | Heart Problem/Defect | | | |
| ADD/ADHD | | | | Hepatitis | | | |
| Anemia (include Sickle Cell) | | | | High Blood Pressure | | | |
| Arthritis | | | | Mononucleosis | | | |
| Back/Neck Injury or Condition | | | | Physical Disability | | | |
| Blood Clotting Disorder | | | | Pneumonia | | | |
| Cancer/Leukemia | | | | Rheumatic Fever | | | |
| Chickenpox | | | | Scarlet Fever | | | |
| Diet Restriction | | | | Surgery | | | |
| Epilepsy | | | | Vision Defect | | | |
| Head Injury/Concussion | | | | Whooping Cough | | | |
| Headaches/Migraines | | | | Other: | | | |
| Hearing Deficit | | | | | | | |

Please give details for all that are marked **YES** above _____

Does your child have contacts/glasses? Yes ___ No ___ Does your child have hearing aide(s)? Yes ___ No ___

Does your child have asthma? Yes ___ No ___ If yes, mild ___ moderate ___ severe ___

Medication taken for asthma _____

Does your child have allergies? Yes ___ No ___ Nature of allergy _____

Mild ___ Moderate ___ Life-threatening ___ EpiPen prescribed? Yes ___ No ___

Does your child have diabetes? Yes ___ No ___ Type I Diabetes ___ Type II Diabetes ___

If yes, insulin, glucometer, pump, and care needed at school _____

Does your child have seizures? Yes ___ No ___ if yes, describe type and meds taken _____

Part II: Current Medications

Does the student take any medication (prescribed or over-the-counter)? Yes ___ No ___ Explain: Include dosage, reason and frequency _____

Is medication required during school hours? Yes ___ No ___ **if yes, please fill out medication authorization form.**

Part III: Consents and Signatures

Yes ___ No ___ **CONSENT TO CONTACT DOCTOR:** The school nurse has permission to contact my child's doctor for health/medical concerns.

I understand that in order to provide the safest possible environment and most complete educational program for my child, the school needs to be informed of any health or medical conditions that may affect my child's school day or impact their learning.

I understand that medications of any kind are not allowed on school grounds without proper medical authorization on file. I understand that school staff, including nurse **MAY NOT** administer or assist with any medications without the proper medical authorization on file.

I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child's condition with appropriate school staff. This will be done in a confidential manner. If I do not wish that information be shared, I must request this in writing and file it with the school nurse.

Parent/Guardian Signature

Date