

PLEASE check any CHRONIC OR RECURRING ILLNESSES OR CONDITIONS:

<input type="checkbox"/> colds	<input type="checkbox"/> urinary problems	<input type="checkbox"/> headache	List drug allergies
<input type="checkbox"/> convulsions	<input type="checkbox"/> hearing problems	<input type="checkbox"/> nosebleeds	_____
<input type="checkbox"/> diabetes	<input type="checkbox"/> earaches	<input type="checkbox"/> nervous conditions	_____
<input type="checkbox"/> epilepsy	<input type="checkbox"/> skin infections	<input type="checkbox"/> others:	List food allergies
<input type="checkbox"/> eye infections	<input type="checkbox"/> streptococcus infection	_____	_____
<input type="checkbox"/> heart murmur	<input type="checkbox"/> tonsillitis	_____	_____
<input type="checkbox"/> orthopedic	<input type="checkbox"/> ulcers	_____	_____

PLEASE give details or history of above that might be helpful information:

Does your child have any conditions which could be a school emergency? Yes _____ No _____

If yes, please explain: _____

Is physical activity limited? Yes _____ No _____ *If yes, please explain:* _____

A PHYSICIAN'S STATEMENT MUST BE SUBMITTED TO THE SCHOOL IN WRITING IF PHYSICAL ACTIVITY IS LIMITED OR RESTRICTED.

In case of EMERGENCY and school officials are unable to contact the parents/guardians of the above named child; you have permission to take this student to a doctor or hospital for EMERGENCY care. This consent shall continue until revoked in writing by a parent or legal guardian of the student. These contact persons listed above are the only ones allowed to sign out my child, unless I otherwise notify the school in writing.

Date

Signature of Parent/Guardian

RELEASE OF INFORMATION:

I understand that certain educational records of my child will be shared with District and Department of Health, health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's Medical Treatment records created by District and Department of Health, health care personnel at school may be shared with school officials who have legitimate educational purpose for accessing such Medical Treatment records.

Date

Signature of Parent/Guardian

Thank you for taking the time to fill out this form. If you have further questions or need to update your child's health information please give us a call. You may contact the Registered nurse or the Health Support Aides at your child's School.

Cate H. Jacob R.N., B.S.N., M.S.N.
Supervisor of the School Health Program