Odebolt Arthur and Battle Creek Ida Grove CSD Health Information

Please fill out the following information and return to school at registration or as soon as possible

Student Name______________________________ Birthdate______________ Grade________

Parent/Guardian's Name____

Health Insurance Coverage: ☐ No ☐ Yes Company:______________________________

I would like information on low-cost income based health and dental insurance such as Hawk-I ☐ No ☐ Yes

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Does your child have any allergies? ☐ Yes ☐ No , IF YES, please list (include medications, food, stings, latex, environmental, or other):______________________________

How does your child react to this allergy?______________________________

If allergy is severe, an emergency health plan will need to be filled out; food allergies require a dietary form to be filled out.

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Medical History(Please check all that apply) ***If your child has asthma we can develop and asthma action plan to have at school.**

☐ Yes	☐ No	Asthma or lung problems*	☐ Yes	☐ No	Seizures
☐ Yes	☐ No	ADD/ADHD/Behavioral issues	☐ Yes	☐ No	Migraine Headaches
☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Hearing Loss/Aids
☐ Yes	☐ No	Bladder/Urinary Problems	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Stomach/bowel problems	☐ Yes	☐ No	Skin conditions
☐ Yes	☐ No	Surgeries/Injuries/broken bones	☐ Yes	☐ No	Glasses/Contacts
☐ Yes	☐ No	Other, if yes please explain			

Comments to any marked:____

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Medication: Does your child take any medication/treatments regularly? ☐ Yes ☐ No, IF YES please list.

	Name of medication(s)	Dosage	Times given	For what condition	To be given at school Y/N?*
1.					
2.					
3.					

***Any medications administered at school require written parental authorization. Over the counter medications must be in the original labeled container and prescription medications must be in the original container and have a current pharmacy label. No over the counter medication will be given outside manufacturers age/weight guidelines without physician authorization.**

Do you give permission for the following to be given to your child while at school according to dosage guidelines on product label?

Non-aspirin acetaminophen (Generic Tylenol)	☐ Yes	☐ No	Tums	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No	Cough Drops	☐ Yes	☐ No
Skin Ointments	☐ Yes	☐ No	Exception of: ______________		

(Including but not limited to: triple antibiotic ointment, sunscreen, burn spray, calamine lotion, itch cream)

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As the parent or legal guardian I authorize basic first aid and emergency medical treatment if necessary in the event of an accident or illness of my child. I understand that all efforts will be made to contact me in the event of an emergency. I give my permission for the school nurse to share relevant health information to appropriate school staff when needed to meet the child's health and safety needs. I give my permission to medical professionals to exchange information for the purpose of referral, diagnosis, and treatment with the Odebolt Arthur Battle Creek Ida Grove school nurse. I give specific permission to my health care provider to share any pertinent health information in my child health record regarding: immunizations, administration of medications, and/or educationally significant health information that may affect my child's learning and or safety at school.

______________________________ Parent/Guardian Signature

______________ Date