Odebolt Arthur 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_____

Parents/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

Does your child have any allergies? ❑ No ❑Yes If YES, please list (include medications, food, stings, latex, environmental, or other): _____
Reaction: _____
If allergy is severe, an emergency health plan will need to be filled out. Food allergies require a dietary form to be filled out.

Medical History: Check all that apply: ❑ None

- ❑ Asthma or lung problems
- ❑ ADD/ADHD/Behavioral Problems
- ❑ Heart Problems
- ❑ Bladder/Urinary Problems
- ❑ Stomach/Bowel Problems
- ❑ Surgeries/Injuries/Broken bones
- ❑ Other, if yes, please explain
- ❑ Seizures
- ❑ Migraine Headaches
- ❑ Hearing Loss/Aids
- ❑ Diabetes
- ❑ Skin Conditions
- ❑ Glasses/Contacts

Comments to CHECKED answers above:

_____
_____
_____

Medication: Does your student take any medication/treatments regularly? ❑ No ❑Yes (Please list)

	Name of medication (s)	Dosage	Time	Indication	Taken 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 at school while at school according to dosage guidelines on product label?

- ❑ No ❑Yes Non-aspirin acetaminophen (Generic Tylenol)
- ❑ No ❑Yes Ibuprofen
- ❑ No ❑Yes Skin ointments (ie: triple antibiotic, hydrocortisone)
- ❑ No ❑Yes Tums
- ❑ No ❑Yes Cough Drops
- ❑ No ❑Yes Participate in non Invasive screenings (ie: dental, vision)

As the parent/legal guardian, I authorize basic first aid and emergency medical treatment if necessary in the event of an accident or illness of my student. 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 student's health and safety needs. I give my permission to medical professional 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 student's health record regarding: immunizations, administration of medications, and or educationally significant health information that may affect my student's learning and or safety at school.

_____ _____
Parent/Guardian Signature Date