

Southwest Allen County Schools

MEDICAL INFORMATION

Grade: ____/Teacher: _____

Student Name: _____ / _____ M/F: ____ Birth Date: _____
(last) (first)

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Student lives with: Both Parents Mom only Dad only Shared Custody

Father's Name: _____ Employment: _____

Father's Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mother's Name: _____ Employment: _____

Mother's Home Phone: _____ Work Phone: _____ Cell Phone: _____

IN CASE OF ILLNESS OR EMERGENCY, FIRST CONTACT IS MADE TO THE PARENT(S). Please list two contacts other than parents for emergency situations.

#1 Name: _____ Phone: _____ Relationship: _____

#2 Name: _____ Phone: _____ Relationship: _____

Medical Information for School Personnel

My child has no medical problems that impact the school day.

Please list any medication your child is currently taking:

<u>Medication</u>	<u>Dose</u>	<u>Time</u>
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List any *severe/life threatening* allergies that require medication.

	Please list specifics
<input type="checkbox"/> Food	_____
<input type="checkbox"/> Insect/Bee	_____
<input type="checkbox"/> Medications	_____
<input type="checkbox"/> Other	_____

Please check the boxes if your child has any of the following issues:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Head Injury/Concussion date: _____
<input type="checkbox"/> Allergies non-life threatening Type _____	<input type="checkbox"/> Migraines with prescription medication
<input type="checkbox"/> Asthma <input type="checkbox"/> has inhaler	<input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Needs Diastat
<input type="checkbox"/> Autism	<input type="checkbox"/> Psychological/Emotional Disorder
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Sickle Cell <input type="checkbox"/> disease <input type="checkbox"/> trait
<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	

Is physical activity restricted? Yes No

If yes in what way? _____

Does the student have a 504 or an IEP? Yes No

Child's Primary Physician: _____

Physician's Phone Number: _____

Individual Health Plans should be in place for students with Asthma, Diabetes, Seizures and Severe Allergies. Some of these Health Plans require the signature of a physician. To ensure the safety of your child, please contact your school nurse as soon as possible to complete these plans.

Consent for Medical Treatment of a Minor Child (This form MUST be signed by a parent/guardian for the current year)

I (We) do hereby state that I am (we are) the parent(s) or legal guardian(s) of the above named student. I (We) realize that my (our) child, while attending school or participating in extracurricular events or field trips sponsored by or attended by his/her school, may become injured or ill to a degree which would require emergency medical attention. In the event of a serious medical emergency and none of the designated contacts can be reached, the above named student may be transported to the emergency room of the nearest hospital to receive medical treatment beyond what can be provided at school. I (We) authorize **JERRY SCHILLINGER**, Principal of **WOODSIDE MIDDLE SCHOOL**, or her designee (an adult over 18 years of age) to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the State in which the event is being held. This consent for medical treatment will remain in effect for the **2015-2016** school year.

Parent/Guardian Signature: _____ Date: _____