**Student Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Grade:** \_\_\_\_\_\_\_

**Please complete all information, even if it has not changed from last year**

**In the event we cannot reach you, whom may we contact?**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** (Please list all and the type of reaction your child has)

Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bee or Wasp or Insect: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EpiPen (In School): Yes No Inhaler (In School): Yes No

**Medical History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

**\*\*Separate consent forms required for daily medications that need to given during the school day; also for as needed inhalers or EpiPens**

**Consent for In Stock Medications:**

The following are available in the nursing office. The licensed or trained personnel may give as needed for student comfort with parent/guardian permission. Medications are available in pediatric forms for younger children. Medications will be given according to the child’s age and weight per dosing instructions, unless otherwise instructed by a parent/guardian.

Please **circle** medications that youwant your child to receive when necessary

**Ibuprofen Tylenol Tums/Antacid Benadryl Cough Drops**

I give my permission for licensed or trained unlicensed personnel to administer the above medications to my child on an as needed basis.

**\*Please see front and back\***

**Health Screenings:**

The district’s School Health Services program supports your student’s academic success by promoting health in the school setting. One way that we provide care for your student is by performing the health screenings. These screenings are not meant to replace an annual visit with your health care provider. During this school year, the following screenings will be completed at school:

**Vision**

* Distance acuity for all students in, KG, Grades 1, 3, 5, 7, 9 and 11.
* Distance acuity for other grades will be done as deemed necessary.

**Hearing**

* Hearing screening for all students in, KG, Grades 1, 2, 3, 5, 7 and 11th.

**Health Appraisals**

* A Height/Weight screening, including Body Mass Index and Weight Status Category Information for all students, KG-12th grade. This information is reported to without student names to the SD Department of Health to be used in their annual Student Health Assessment.

Parents will be notified of any concerns identified during a screening so their child can be further evaluated by the provider of the parents’ choice.

**My child can participate in school health screenings**

(Please Circle) Yes No

**Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**