Macon County R-IV School

Student Health Inventory

Name: **Grade:**

Address: **Birthdate:**

Contact:	**Contact:**
(Mother) H) W) C) Email:	(Father) H) W) C) Email:

Physician:		**Health Insurance:**	
Dentist:		**Dental Insurance:**	
Vision:		**Vision Insurance:**	

ADD/ADHD	NO	
Allergies	NO	
Asthma	NO	
Diabetes	NO	
Epilepsy/Seizure	NO	
Heart Condition	NO	
Bone or Joint Problem	NO	
Other:		

Wears Glasses: Yes No	**Hearing Aides: L R No**	**Tubes in Ears: L R No**	**Special Diet: Yes No**

Current Medication:

Listed below are the temporary medications available at school if an illness or injury arises. The medications may be generic, and doses will be determined by the manufacturer's label. Please cross through any medication you DO NOT want your child to receive at school.

Tylenol, Ibuprophen, Benadryl, Antacids, Cough Drops, Eye Wash, Eye Drops, Anbesol or Orajel, Sore throat Spray, Triple Antibiotic Ointment, Peroxide, Band-aid, Anti-Itch Lotion/Cream.

In the event of an anaphylactic emergency, I authorize trained school personnel to administer pre-filled epinephrine (Epi-Pen) if available.

No medications will be given the first hour after arriving, or the hour prior to leaving school, unless stated by a doctor.

I authorize trained school personnel to administer first-aid and medication to my child under the direction and supervision of the school health nurse.

In the event that my child is injured or becomes ill and/or needs medical attention for any reason, and I cannot be contacted, this authorization will serve as my request and authority for school authorities to call an ambulance service for the purpose of conveying my child to the hospital or physician, and I authorize any and all medical treatment provided to my child. I hereby authorize the school to provide to the attending physician, hospital or clinic relevant data judged necessary for treatment from my child's file. I fully understand that I shall be responsible for all costs of ambulance service and any medical care or treatment provided to my child. I also give permission for the sharing of health information with appropriate staff members and medical personnel when necessary for my child's health and safety.

Signature of Parent/Legal Guardian_____

Date_____