ROCK PORT R-2 HEALTH FORM

DATE___________________ GRADE_________________ DATE OF BIRTH___________________

In the event your child gets sick or injured in any way at school and needs your attention, a doctor's care, or emergency, the school needs the following information:

STUDENT'S NAME____

HOME ADDRESS____

HOME TELEPHONE___________________________ CELL PHONE_________________________

MOTHER'S NAME____________________________ WORK NUMBER_______________________

FATHER'S NAME_____________________________ WORK NUMBER_______________________

IF you cannot be reached,. List two persons who will assume temporary care of your child.

NAME_____________________ PHONE____________________ RELATIONSHIP______________

NAME_____________________ PHONE____________________ RELATIONSHIP______________

Who is your family doctor?_____________________________ Phone:__________________________

Check if child has or had any of the follwing:

Allergies_____ Asthma_____ Hearing problems_____ Tubes in ears_______ Diabetes___________

Vision problems______ Glasses or contacts_____ Seizures_____ Blood Pressure Problems_______

Heart problems______ Scoliosis_____ Chickenpox_____ Chickenpox Vaccine_____ Headaches____

Daily medications______ Please list:____

May Tylenol be dispensed to your child if, upon examination by the nurse, it is indicated? YES___ NO__

May the school nurse give your child medication sent from home? YES____ NO_____

Grades 4-8: Scoliosis Screening will be done routinely unless school nurse is contacted.

In the event your child needs immediate emergency care, do you consent to allow the principal, nurse, or any school personnel to take your child to the doctor or hospital if you or the contact people listed above cannot be reached? I will not hold the school district financially responsible for the emergency care and/ or transportation for my child. The nurse may share the information with his/her teacher. If you consent, please sign below.

I GIVE MY CONSENT____

I authorize any physician or health care provider to release medical information to the Rock Port R-2 School Nurse upon presentation of this release or a copy thereof.

I GIVE MY CONSENT____