CAMDENTON R-III STUDENT HEALTH CARD

Grade:_____ M:____ F:_____

Age:_____ Birth Date: _____

STUDENT NAME:_____
(Last) (First) (Middle)

K-6 Teacher Name: _____

HOME PHONE: _____

PARENT/GUARDIAN NAME: _____

MOM'S WORK:_____ Cell:_____

ADDRESS: _____

DAD'S WORK: _____ Cell:_____

CITY:_____ZIP:_____ BUS #: _____

STUDENT'S CELL:_____

IN CASE OF ILLNESS OR INJURY AND PARENTS CANNOT BE REACHED, THE SCHOOL SHOULD CALL *(List in order you want called first):*

Name:_____Relationship:_____ Phone #(s): _____

Primary Dr:_____ City/State:_____ Specialist Dr:_____ City/State: _____

MEDICAL CONDITION
(check mark where appropriate)

__ Glasses/Contacts . . . . __ Hearing Aids/Implants
__ **Diabetes**-Diet or Oral Medication
__ **Diabetes** with Insulin __ Pump
__ **Seizures/Epilepsy** __ Medication ordered
__ **Heart Condition** __ w/ Restrictions
__ **Asthma** . . . . . __ w/ Inhaler
__ Nebulizer . . . . . __ Oral Medication
__ **ADD/ADHD** . . . . . __ Medication
__ **Migraines** . . . . . __ Medication
__ **Bee Sting Allergy** __ EPI-PEN
__ **Food Allergy** . . . . . __ EPI-PEN-food name
__ Other conditions: _____

_____

MEDICATION ALLERGIES

_____

MEDICATIONS MY CHILD IS CURRENTLY TAKING:

_____

_____

_____

HEALTH INSURANCE

___ Private Type ___ Medicaid
___ MC+ ___ None

1. EMERGENCY STATEMENT: I hereby authorize the school to seek emergency medical help, including an ambulance, if I cannot be contacted. I understand that the school does not assume responsibility for payment of any medical services.

2. SPECIAL HEALTH CARE NEEDS STUDENTS: I understand that it is my responsibility to supply the school with any and all medical or dietary supplies that will be needed by my student during the school year for his/her special medical care needs. Examples of this may be: Diabetic injection medications and supplies, including glucometer and daily snacks; Epipens; Inhalers and Nebulizer medication and tubing.

3. MEDICATION STATEMENT: I give permission for the following meds to be administered to my student while at school:

YES____ NO____ TYLENOL/GENERIC
YES____ NO____ MOTRIN/GENERIC
YES____ NO____ BENADRYL/GENERIC
YES____ NO____ Other over-the-counter medications
(cough drops, eye drops, antacid,anti-itch cream, antihistamine,antibiotic ointment,antidiarrheal)

4. NO OVER-THE-COUNTER Meds will be given to student without parent/gaurdian signature on this card.

5. PRIVACY STATEMENT: I hereby authorize the mutual exchange of health records regarding the above-mentioned student. I give permission for this information to be exchanged between the Camdenton School Health Services staff and any other staff member involved in the welfare of this student. I also give permission for my student's health information to be exchanged with the physicians listed for primary care of my student.

6. I have read and completely understand the statements above and have specified which medications my student may or may not have while at school.

_____ _____
Parent/Guardian's Name **Date** **Print Name**

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