Confidential Student Medical Information & Consent

School_____ Year_____

Student Name_____DOB_____Grade_____ Teacher _____
Parent/Guardian _____
Home phone _____Work phone _____Cell phone _____

Medical Diagnosis by Physician: (Check all that apply) **MUST BE UPDATED EACH SCHOOL YEAR**

- ☐ Allergy
  - ☐ Food (list below)
  - ☐ Environmental
  - ☐ Insect
  - ☐ Latex
  - ☐ Medication (list below)
  - *☐ EpiPen ☐ Benadryl ☐ Auvi-Q
- ☐ Arthritis
- ☐ Autism Spectrum Disorder
- ☐ Autoimmune Disorder
  - List_____
- ☐ Bowel/Bladder Problem (circle)
  - ☐ Ostomy ☐ Cath ☐Incontinence
- ☐ Cancer_____
  - ☐ Port ☐ Remission date_____
- ☐ Chronic Pain
  - Location_____
- ☐ Diabetes
  - ☐ Type I ☐ Type II
  - ☐ Pump ☐ Pen ☐ Syringe ☐ Pill
- ☐ Developmental Disorder
  - ☐ Down's Syndrome
  - ☐ Mental Retardation
  - ☐ Other _____
- ☐ Ear/Nose/Throat Disorder
  - List_____
- ☐ Feeding Needs
  - ☐ NG ☐Peg ☐Mic-key
  - Other_____
- ☐ Gastrointestinal Disorder
  - ☐ Constipation
  - List _____
- ☐ Genetic Disorder
  - List _____
- ☐ Hearing Impairment
  - ☐ Hearing Aide(s)
  - ☐ Cochlear Implant(s)
- ☐ Heart Condition
  - List _____
- ☐ Hemophilia
  - Other bleeding D/O _____
- ☐ History of Head Injury
  - Number of concussions_____
- ☐ Kidney Disorder
  - List _____
- ☐ Headaches
  - ☐ Migraine ☐ Cluster
- ☐ Musculoskeletal Disorder
  - List _____
- ☐ Psychological Disorder
  - ☐ ADHD/ADD (circle)
  - ☐ Anxiety
  - ☐ Behavioral
  - ☐ Bipolar
  - ☐ Depression
  - ☐ Mood Disorder
  - ☐ OCD
  - ☐ Psychosis
  - ☐ Other _____
- ☐ Neurological Disorder
  - ☐ Cerebral Palsy
  - ☐ Hydrocephalus
  - ☐ Seizure Disorder
    - ☐ Diastat ☐ Clonazepam
  - ☐ Spina Bifida
  - ☐ Other _____
- ☐ Oral/Dental Disorder
  - ☐ Cleft Palate
  - ☐ Other _____
- ☐ Respiratory Disorder
  - ☐ Asthma; Last event_____
  - ☐ Cystic Fibrosis
  - Other_____
- ☐ Speech Disorder
- ☐ Surgical procedures
  - List _____
- ☐ Thyroid Disorder
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism
- ☐ Visual Impairment
  - ☐ Contacts ☐ Glasses
  - ☐Other , list _____

Currently receiving support services:
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy

Any assistive devices utilized:
- ☐ wheelchair
- ☐ AFOs or other orthotic device
- ☐ Crutches
- ☐ Scooter
- ☐ Prosthetic device
- ☐ Other _____

Other pertinent information that may affect your child throughout the school day:_____
_____
_____
_____

PLEASE NOTE BOARD APPROVED EMERGENCY MEDICATIONS:
EPINEPHRINE will be administered in the event a student is thought to be experiencing an ANAPHYLACTIC REACTION.
NALOXONE (NARCAN) will be administered in the event a student is thought to be experiencing an OPIOID OVERDOSE.

Do you feel your child has a disability that substantially limits one or more major life activities? ☐ Yes, ☐ No
Is your child currently on an Individualized Education Plan (IEP) or a Section 504 Plan? (circle) ☐ Yes, ☐ No

Allergies to *food or medication(s) _____
Current medication(s) and reason for taking: _____
_____

Physician	Phone	Last seen
Specialist (if applicable)	Phone	Last seen
Dentist	Phone	Last seen
Is your child covered by medical insurance? ☐ Yes ☐ No		
Is your child covered by dental insurance? ☐ Yes ☐ No		

_____Initials I give permission for the above information to be shared in confidence with appropriate staff and emergency personnel. In the event of an emergency, I authorize school personnel to obtain emergency medical care and/or emergency transportation by ambulance.

_____Initials I give permission for the exchange of medical health information both <u>verbal</u> and <u>written</u> between my child's physician and the Kearney R-1 School District health room staff. All health information is kept confidential.

Parent Signature_____***Date***_____

* If your child has a medical condition or food allergy that requires a special diet, you must submit a <u>Medical Statement for Student Requiring Special Meals</u> form. Form must be completed by your physician for the omission and/or substitution of any food(s). OVER

OVER THE COUNTER MEDICATION ADMINISTRATION AUTHORIZATION FOR AGES 12 AND OLDER

- Acetaminophen (generic for Tylenol) and ibuprofen will be made available to students (ages 12 and older) with parent/guardian authorization
- A student cannot exceed more than 20 doses of any combination of acetaminophen and/or ibuprofen in a single school year
- If additional doses are requested, a written order from a physician and parent/guardian authorization are required; a parent/guardian must also provide the additional medication to the nurse for the student
- The Kearney R-1 School District will not be held accountable for the dispensation of over the counter pain relievers in accordance with a signed permission form from the parent/guardian. Upon submission of the signed release for dispensation, the parent is responsible to notify the district in writing should this allowance need to be discontinued.
- Permission forms are good for one academic year and must be renewed annually.

Student Name: _____ Date of Birth: _____

My child may receive:

☐ **Ibuprofen 200mg 1-2 tabs**

☐ **Acetaminophen 325mg 1-2 tabs**

Other instructions/requests: _____

_____

☐ **I understand and agree to the above terms.**

Parent/Guardian Signature _____ Date: _____