ANNUAL MEDICAL INFORMATION Complete and return with enrollment

Student _____ _____ DOB _____ GRADE _____
(LAST) (FIRST)

Parent _____ Home # _____ Work # _____ Cell # _____

Parent _____ Home #_____ Work # _____ Cell # _____

Emergency contact name _____ Phone # _____ Phone # _____

Doctor's name _____ Preferred Hospital _____

Confidential information may be shared with teaching staff only if necessary-please notify nurse of changes

Medical condition	**Yes**	**Comments**
ADD, ADHD		Medications:
Allergies (seasonal, food, drug, latex, insect)		Indicate type: Treatment:
Asthma, respiratory issues		Triggers: Inhaler:
Bleeding tendency		
Diabetes Type 1 or Type 2		Insulin or Oral medication
Headaches, migraines		Triggers: Treatment:
Hearing problems		
Heart problems		
Hypoglycemia		
Muscle/skeletal problems		
Psychological disorders		
Seizures: type Date of last		Medications:
Shunt, spinal bifida		
Stomach or bowel disorders		
Surgeries		
Traumatic brain injury, concussions		
Vision: glasses contacts		
Other health information		

The nurse can provide an **I**ndividualized **H**ealth Care **P**lan for any student with an identified health concern. The IHP provides information on treatment and how to meet those needs. Do you feel that your child is in need of an IHP?

Yes No

Does your child take any medication on a regular basis? If yes, please list medications and time taken

_____

_____

(Continued on other side)

Student's name _____

Over the counter medication permission

All prescription medications administered at school require written parent permission and written authorization from a physician or a copy of the pharmacy label. Forms are available from the school nurse.

Over the Counter Treatment Permission: Place a mark (X) by each over the counter treatment (OTC) you approve of for use for your child. Please remember that it is the parent's responsibility to provide any OTC medication that is taken on a regular basis.

____ Acetaminophen (Tylenol) for minor headaches, aches, pains per package directions
____ Antacids (Tums or equivalent) for occasional stomach indigestion complaints
____ Antibiotic ointment for minor cuts and scrapes
____ Benadryl oral for allergic reactions per package directions
____ Calamine, hydrocortisone cream for minor rashes, bug bites, poison ivy
____ Ibuprofen (Advil, Motrin) for headaches, minor aches and pains per package directions
____ Midol, Pamprin

I authorize the use of the above named over the counter products for my child unless specifically revoked by me**.** He/she has used these products in the past without adverse effects or reaction. I further understand that any school personnel of USD 394 who administers such treatment to my child pursuant to written parental permission will not be held liable for any adverse reactions that may occur as a result of administering such treatment. **I understand that it is my responsibility to notify the school nurse of any changes in health status or medications.**

Parent Initials _____

Consent to receive medical treatment

I, the undersigned being the natural parent or legal guardian of the above named student, do hereby consent to the securing of emergency treatment, including necessary transportation to receive such treatment by the Superintendent or by his/her designee of Rose Hill Schools USD 394, which is in effect until specifically revoked by me.

Parent Initials _____

Authorization for release of immunization information

I hereby authorize USD 394 to release immunization information in their possession related to the above student to the Kansas Immunization Registry.

Parent initials _____

Parent or guardian signature _____ Date_____

Teri Koester, HS/MS RN
Lindsay George, ES/IS RN
Janis Engels, MS Health Aide
Christy Franz, ES/IS Health Aide

ES Phone#	316-776-3385	FAX # 776-3368
MS Phone #	316-776-3380	FAX # 776-3318
HS Phone #	316-719-2808	FAX # 776-3378
	316-776-3360	