North Cedar Student Health Information Form 2024-2025

Last Name_____ First Name_____ DOB_____ Grade_____
Student Address_____
Parent/Guardian Name_____ Phone_____
Parent/Guardian Name_____ Phone_____
Local emergency contact in the event neither parent/guardian cannot be reached:
Name_____ Phone_____ Relationship_____
Name_____ Phone_____ Relationship_____

Primary Health Care Provider_____ Phone No_____
Dentist_____ Hospital Preference_____
Type of Insurance _____None _____ Hawk-I _____Private _____Medicaid
List all medications your child is taking:
At home:_____
At school:_____
Please check one _____My child does not have any specific health problems at this time **OR**
_____ My child has the following health problems (check all that apply)
____Allergy (Please describe)_____ Is EPIpen needed at school ____Yes ____No (Parent must supply)
____Asthma _____ Inhaler is needed at school (Parent must supply) _____ Inhaler is NOT needed at school
____Diabetes _____ Seizures _____ Bleeding Disorder _____ ADD/ADHD
____ Heart Condition _____ Skin Condition _____ Bone/Muscle Condition _____Other_____
Comments:_____

Administration of Over-the-Counter (OTC) Medications

☐ **I give permission for the school nurse/certified staff to administer to my child, as appropriate and per manufacturer's instruction, the following OTC products as checked. These preparations may be administered throughout the 2018/19 school year without prior phone call:**
☐ Acetaminophen 500 mg 1 tab____2 tabs____ ☐ Ibuprofen 200mg 1 tab____2 tabs____
☐ Children's Chewable Tylenol 80 mg Dose_____ ☐ Antacid/TUMS ☐ Benadryl 25mg____
☐Triple Antibiotic Ointment____ ☐ Hydrocortisone 1% Ointment ☐ Lip Balm
☐ **All Over The Counter Medication Listed May be Given**
☐ **I DO NOT give permission to administer the listed OTC medications.**

*I give the emergency contact permission to release my child from school for medical reasons if I cannot be reached
*I give permission to the appropriate personnel of the North Cedar Community School District to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary and in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment.
*I understand that by checking that I give permission to administer OTC medications, that I give permission to designated school personnel to give medication to my student during the school day and I further agree to hold the North Cedar Community School District and employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.
*I understand that if my student comes to the health office multiple times with the same complaint, that I may be notified for referral for further evaluation and/or to bring personal OTC medication to health office for administration.
*I verify that the information on this form is correct and understand that it is my responsibility to notify the school whenever there is a change in my child's health status or care. I understand that this information is confidential but the information with be shared with other school personnel as needed.
*The school district may offer vision, hearing and/or dental screenings. Students are automatically screened unless the parent submits a signed note excusing the student from the screening(s) at the beginning of the school year.

Parent/Guardian Signature_____ Date:_____