WHITING COMMUNITY SCHOOL HEALTH INFORMATION FORM

Name of Student_____

Birth Date: ___/___/___ Grade: _____ Gender: Male/Female

Parent/Guardian(with whom the child resides) _____

Address :_____

Phone#_____ Cell#_____ Work#_____

Persons to Contact in an Emergency:

1) Name_____Relationship to Child_____

Phone #_____Cell#_____Work#_____

2) Name_____Relationship to Child_____

Phone#_____ Cell# _____ Work#_____

Healthcare Provider Information:

Physician/Clinic: _____

Phone# _____Hospital preference _____

Health Information:
To the best of your knowledge, does your child have any problem that may affect his/her learning in school that would cause any concern and/or be important to know? YES NO
If yes, please elaborate:

_____

_____

Has your student been diagnosed by a physician for: (circle yes or no)

yes	no	asthma or bronchospasms	Yes	no	ADD/ADHD/behavioral problem
yes	no	Diabetes	Yes	no	Seizures/epilepsy
yes	no	Heart problems	Yes	no	Migraine headaches
yes	no	Blood pressure problems	Yes	no	Depression/anxiety
yes	no	Kidney/urinary problems	Yes	no	Stomach/bowel problems
yes	no	Hearing problems	Yes	no	Vision problems
yes	no	Scoliosis	Yes	no	Broken bones (where)
yes	no	Chicken pox	Yes	no	Head injuries
yes	no	Allergies	Yes	no	Toileting
		(reaction)	Yes	no	Speech

(TURN OVER-CONTINUED ON BACK PAGE)

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Comments to any 'yes' items from health information or any other additional information:

_____

_____

Does your child take any prescription or OTC medications? _____ yes _____no Will your child take these medications at school? _____yes _____no If yes, please fill out the Medication Administration Permission Form and return it to the school with the medication to be given. We will not give any prescription medications without this form being completed.

(If your child will be taking medications at school, he or she has to have written consent from a parent or guardian. All OTC medications have to be in the original container. Any prescription medications must be in the original container from the pharmacy and be a current prescription.)

My child has permission to take Acetaminophen (Tylenol) and/or Ibuprofen per package instructions and per age appropriate. YES NO
My child has permission to take 1 or 2 TUMS for upset stomach. YES NO
My child may take cough drops as needed for cough or cold symptoms. YES NO
My child may have antibiotic ointment or hydrocortisone cream applied to the skin for minor scratches, irritation, or rashes. YES NO

I give permission for the above student to be given the medications marked with a YES to be given at school and/or school activities by qualified staff, according to the prescription or non-prescription instructions. A record of administration will be maintained by administering staff. Parent/Guardian will be notified upon five or more uses and an alternate plan or doctor's note may be requested. I verify that the student has experienced no previous side effects from these medications. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand that the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonable prudent person would under the same or similar circumstances.

I also give permission for the school nurse or other trained personnel to perform routine health screenings that may include hearing, vision, height, weight, or lice checks. Parent or guardian contact will be made with abnormal screenings. I authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. ***This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health record.***

I understand that the information provided in this form is confidential and only shared, when necessary, in the best interest of your child. Please be aware that staff and administration persons do have access to health information only when necessary.

Signature or Parent or Legal Guardian _____ Date _____

I verify that this information hasn't changed from the previous year and if it has, the necessary changes have been noted. (initial below)

Pam Madsen,
RN School Nurse
712-455-2468
pmadsen@whitingcsd.org

2024 _____ 2025 _____ 2026 _____

2027 _____ 2028 _____ 2029 _____