Student Health Information *and* Consent for Medical Treatment of a Minor Child

Please Complete Both Pages of Form

In order to keep your child's health record current, we would appreciate you completing the ***front and back*** of this form.

Student Name ______________________________ Date of Birth ______________

Address ______________________________ Phone ______________ Grade ____

***Unless a child's injuries are life threatening, hospital personnel and physicians cannot treat him/her without parental/guardian consent. As a result, your child may suffer unnecessary discomfort while waiting for you to be reached to approve care. Your child cannot be treated for non-emergency conditions without your consent.**

I, ______________________________ (Check one) ☐ parent ☐ legal guardian of
(Parent/Legal Guardian's Name)

______________________________ authorize the rendering of such care, including diagnostic procedures, surgical
(Child's Name)
and medical treatment, and blood transfusions, by members of the hospital staff, as deemed necessary in their professional judgment. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments of my child's condition. I have read this form and I certify that I understand its contents. I hereby give my consent, for this school year, to the designated employee of Whitley County Consolidated Schools to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of my child. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered while my child is at the school event. WCCS employees will not be responsible for any unpaid bills or charges.

Signature______________________________Date______________________________
(Parent/Guardian Signature)

Number each item 1, 2, and 3 in order of your desired action in case of emergency:

____ Contact father at ______________________________ Phone ______________

____ Contact mother at ______________________________ Phone ______________

____ Contact a ☐ relative ☐ friend Name ______________________________ Phone ______________
(check one)

Check Yes or No: **Contacts:** ☐ Y ☐ N **Glasses:** ☐ Y ☐ N **Inhaler:** ☐ Y ☐ N

Family Doctor ______________________________ Phone ______________

Hospital Preference ______________________________ Insurance Carrier ______________

Student Name: ______________________ Grade: __________

Has your child experienced <u>within the past 12 months</u> and/or been diagnosed with:
(list any other health conditions and any information which would help in protecting your child's health under other conditions)

ADHD/ADD	☐	Anxiety Disorder	☐	Cerebral Palsy	☐	Diabetes Type I	☐	Hemophilia	☐	Multiple Sclerosis	☐
Allergy - Food	☐	Asthma - Severe	☐	Conduct Disorder	☐	Diabetes Type II	☐	Sickle Cell Anemia	☐	Obsessive Compulsive Disorder	☐
Allergy - Insect	☐	Asthma - Moderate	☐	Chrohn's Disease	☐	Eating Disorder	☐	Juvenile Arthritis	☐	Post Traumatic Disorder	☐
Allergy - Latex	☐	Asthma - Mild	☐	Cystic Fibrosis	☐	Epilepsy/ Seizures	☐	Osteogenesis Imperfecta	☐	Spina Bifida	☐
Allergy - Medication	☐	Bipolar Disorder	☐	Depression	☐	Heart Disease	☐	Muscular Dystrophy/ ALS	☐	Tourettes	☐
Anemia	☐	Cancer	☐	Methicillin Resistant Staphylococcus Aureus (MRSA)							☐
Chromosomal Abnormalities (excluding Down's Syndrome) (Includes Prader-Willi, Fragile X, Marfans, Klinefelter, Turner, and Williams)											☐
Other physical condition that requires long-term monitoring and/or management											☐
Other mental condition that requires long-term monitoring and/or management											☐

List any Medications your child is currently taking and Reason for taking medication:

List any surgery(s) your child has had and specify the date the surgery was done:

<u>BEE STING ALLERGY</u>

☐ (1) my child has shown a reaction to bee stings and my doctor has recommended the following medication to be given:

____

I will bring this medication to be kept at the school and fill out the necessary form.

☐ (2) my child is **severely** allergic to bee stings. My doctor prescribes that an Epipen be readily available at school.

<u>ALLERGIES</u>

☐ (1) my child is allergic to the following (*non - food items*) ______________________

And has shown the following reaction: ______________________

☐ **(2)*** my child is allergic to the following (*food or drink*) ______________________

And has shown the following reaction after eating or drinking it: ______________________

☐ (3) my doctor prescribes that an Epipen be readily available at school, and

I ***will supply the school with an Epipen*** **(If an injection is needed for either bee sting or allergies, the student may be transported to the hospital *at parent cost* if an ambulance is necessary.)**

****A medical doctor's note stating the child's allergy and what should be substituted must be on file in the school office before Food Services can make substitutions in the menu for your child. See the school nurse for more details.***

<u>ASTHMA</u>

Name of Medication	Dosage	Times Given

* ***I will comply by supplying the school with an inhaler to be used should my child have an asthma attack.***

SYMPTOMS my child exhibits when experiencing difficulty with asthma:

SPECIFIC INSTRUCTIONS if my child has an asthma episode: