SISTERS SCHOOL DISTRICT STUDENT HEALTH CONCERNS 2023-2024

Re:_____ _____/_____/_____
(student name/grade) (birthdate)

Parent/Guardian:_____ Daytime Phone Number:_____
PRINT

Does your student have any current medical concerns: □ Yes □ No
Is your student covered by health insurance? □ Yes □ No
If no, would you like more information? □ Yes □ No
In case of emergency, do you give permission for your child to be transported to the nearest facility and for their staff to provide the necessary treatment until you arrive? □ Yes □ No

My child has the following medical concern(s) (please check all that apply)

□ ADD/ADHD
□ Asthma
□ Bleeding Disorder (specify)_____
□ Cardiac Condition (specify)_____
□ Diabetes Type 1 _____ Type 2 _____
□ Eating Disorder (specify)_____
□ Eye/Ear Problem (specify)_____
□ Food Allergies (specify) _____
□ Insect Allergy (specify) _____
□ Medication Allergy (specify) _____
□ Muscle/Bone/Joint Problem (specify) _____
□ Recurrent Headaches _____
□ Seasonal/Environmental Allergies _____
□ Seizures (specify what kind) _____
□ Surgery (specify and indicate date) _____
□ COVID-19 positive date_____ Lasting Symptoms □ Yes □ No
□ Traumatic Brain Injury/Concussion Date_____
□ Other (specify) _____

Nurse's Notes

□ My child is taking medication at home (prescription, over-the-counter, daily or as needed) (specify):
_____
□ My child will need medication during school hours: Inhaler/Epi-Pen/Other (specify):
_____

(Students who require an Epi-Pen will bring dose to office and have an emergency protocol on file)

If your child ***does*** have a medical concern, the nurse will contact you to obtain more information and to plan for the upcoming school year.

- ***If any changes occur or a new condition is diagnosed during the school year, I, the parent/guardian, will notify the school nurse of the new status by providing a new student health concern form. Overnight trips might require additional forms.***

Parent/Guardian Signature:_____Date:_____

Release of Confidential Information: For your child's safety and well-being while at school and on field trips, it may be beneficial for appropriate school personnel to be informed of any medical conditions included on this medical authorization form. Please be assured the staff will keep this information confidential. If you do not want medical information shared, please indicate to the school in writing on this form.

RETURN FORM TO SCHOOL OFFICE

SISTERS SCHOOL DISTRICT

SELF MEDICATION CONTRACT BETWEEN STUDENT, PARENT AND SCHOOL

Permission for _____ to self-administer medication at school:
(Student name)

Student contract for self-administration of asthma inhaler or other medication:

1. Student has demonstrated to the nurse correct use of medication.
2. Student agrees to never share the medication with another person, or to misrepresent medication to other students.
3. Student will bring only one day's dose of medication to school each day, unless prior arrangement with nurse and parent has been made.
4. Student may be subject to discipline, up to and including expulsion, as appropriate if the Board's policy or regulations regarding self-administration of medication is violated.
5. In the case of asthma inhalers, the student agrees that after two puffs, if there is not marked improvement, he/she will go to see the nurse immediately.

Student Signature_____ Date:_____

Parent permission:

I give permission for my child to carry the medication described below. This medication is to be used for treatment listed below and is to be given to allow the student to remain in school. I understand that he/she must follow the rules listed above. I will notify the school of changes in medications or my child's condition. I understand that according to school policy, permission to self-medicate may be revoked if the student violates the Board's policy or regulations governing administering medicines to students. In addition, students may be subject to discipline, up to and including expulsion, as appropriate. Students in grades 9 through 12 only may carry medications other than asthma inhalers.

NAME OF MEDICATION	DOSE/ROUTE	FREQUENCY OF USE	CONDITION FOR WHICH MEDICATION IS USED

Start date: _____ Stop date: _____

Parent name: _____

Parent signature: _____ Date: _____

Nurse signature: _____ Date: _____