



PLEASE RETURN WITH REGISTRATION FORMS

HEALTH ASSESSMENT FORM

(School)

STUDENT INFORMATION

Name of Student, Home Address, Date of Birth, Mother/Guardian's Name, Father/Guardian's Name, Dad Cell Phone, Physician, Dentist, Grade, Sex, Phone, School last attended/Location, Day Phone, Mom Cell Phone, Hospital

EMERGENCY CONTACTS (in cases when a Parent/Guardian cannot be reached)

1. Name, Day Phone, 2. Name, Day Phone

HEALTH CONDITIONS (check those that apply)

Table with 2 columns of health conditions: ADD/ADHD, Allergies, Arthritis, Asthma, Behavioral, Blood Disorder, Brain/CNS Disorder, Cancer, Cardiovascular, Cerebral Palsy, Cystic Fibrosis, Developmental Delay, Diabetes, Eating Disorder, Endocrine Disease, G.I. Disorder, Genetic Disorder, Hearing Impaired, Migraine Headaches, Musculoskeletal Disorders, Prosthesis, Seizure Disorder, Skin Disease, Spinal Bifida, Urinary/Kidney Disease, Visually Impaired

Surgical History/Other (Please List):

- Please fully explain any answers checked above (include severity and symptoms of any allergies)
Please list any medication(s) the student takes on a regular basis
Please list any physical education restrictions if applicable
Please list any other factors that the school nurse, counselor or your child's teacher(s) should know of which might affect the student's school experience

504 Plan on file? YES NO

I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Parent/Guardian Signature

Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM



Blue Valley School District
Student Services
Consent for Administration of Approved Over-The-Counter Medications

Name of Student _____

Grade _____

Please check the medications you would like to be made available to your child:

Not all of the medications listed below are stocked in every health room

- Acetaminophen (like Tylenol)
- Ibuprofen (like Motrin or Advil)
- Antihistamines (like Benadryl or Zyrtec for allergy symptoms)
- Lotions, creams or ointments (like Calamine, Cortaid, Bacitracin)
- Throat Lozenges/Cough Drops
- Antacids (like Tums)

School personnel must have parental consent in order to administer over-the-counter medications. Generic equivalents maintained in the Health Room may be used in place of more expensive brand-name items. The School Nurse or delegated staff person will administer the approved medications as deemed necessary using his/her judgement. **If parents send over-the-counter medications to be administered at school, they must be in the original container accompanied by a note explaining the reason for the medication.**

- Please list any medication(s) the student takes on a regular basis if you have not done so on the opposite page.

- Please list any medication allergies if you have not done so on opposite page: _____

- I hereby give permission for my child to receive any medication checked on this form, as deemed necessary by the school nurse or delegated staff person.

I understand that any school employee who administers these medications according to proper dosages shall not be held liable for damages as a result of an adverse reaction to the medication administered.

Parent/Guardian Signature

Date

OR

- I **DO NOT** want any medications given to my child at school.

Parent/Guardian Signature

Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM