PLEASE RETURN WITH REGISTRATION FORMS

_____ HEALTH ASSESSMENT FORM
(School)

STUDENT INFORMATION

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

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)

☐ ADD/ADHD	☐ Eating Disorder
☐ Allergies (Life Threatening)	☐ Endocrine Disease
☐ Allergies	☐ G.I. Disorder (Stomach/Intestinal)
☐ Arthritis/Connective Tissue	☐ Genetic Disorder
☐ Asthma/Reactive Airway	☐ Hearing Impaired
☐ Behavioral/Emotional/Psychological	☐ Migraine Headaches
☐ Blood Disorder	☐ Musculoskeletal Disorders
☐ Brain/CNS Disorder	☐ Prosthesis
☐ Cancer	☐ Seizure Disorder
☐ Cardiovascular (Heart/Blood Disease)	☐ Skin Disease
☐ Cerebral Palsy	☐ Spinal Bifida
☐ Cystic Fibrosis	☐ Urinary/Kidney Disease
☐ Developmental Delay	☐ Visually Impaired
☐ Diabetes	

☐ 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

_____ _____
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