PLYMOUTH COMMUNITY SCHOOL CORPORATION

STUDENT HEALTH INFORMATION

Student Name _____ Grade _____

Part I: Medications

Does your child take daily medications? ○ Yes ○ No Taken for _____
Medication taken at home _____ Dosage/time _____
Medication to be given at school _____ Dosage/time _____

Does your child take herbal products? ○ Yes ○ No Specify _____

Part 2: Allergies

Does your child have allergies to medication, food, bee stings, environment? ○ Yes ○ No
Medication allergy _____ Food Allergy _____
Bee sting allergy _____ Other _____
Type of reaction _____ Requires Epi-pen? ○ Yes ○ No

Part 3: Medical History (please check all that apply)

Current	*Resolved*		*Current*	*Resolved*	
☐	☐	Asthma	☐	☐	Migraine Headaches
☐	☐	Diabetes	☐	☐	Heart Problems
☐	☐	Attention Deficit Disorder	☐	☐	Seizures/Epilepsy
☐	☐	Bowel/Bladder Problems	☐	☐	Nosebleeds
☐	☐	Handicaps/Disabilities	☐	☐	Surgeries/Serious Injuries
☐	☐	Hospitalizations	☐	☐	Other _____

☐ Wears Glasses ☐ Wears Contacts ☐ Wears Hearing Aid(s)

Part 4: Special Needs

List any treatments or care that the nurse needs to perform for your child at school: i.e. nebulizer treatments, tube feedings, catheterizations, suctioning, etc.

I give permission for the above information to be shared with my child's teacher(s).

PERMISSION TO TRANSFER/TREAT – RELEASE OF INFORMATION

I hereby give permission to transport _____ (student's name) by ambulance to the nearest emergency facility when urgent care is deemed necessary by school personnel. I understand that the family is responsible for the cost of this transfer and any medical treatment received. I understand the above information is essential to plan appropriate care, and by my signature, allow the Plymouth Community School Corporation to release this information to the ambulance and hospital personnel. It is understood that this information is to remain confidential.

It is also understood that every effort will be made to contact the parent before treatment. In the event that my child arrives at the hospital before I do, I hereby give permission to the emergency staff to render any and all EMERGENCY care until my arrival.

This permission slip is valid for the 20___ - 20___ school year.

Parent/Guardian Signature _____ Date _____
Home Phone _____ Work Phone _____ Cell Phone _____
Physician Name _____ Phone Number _____
Emergency Contact _____ Phone Number _____