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# Student Health Information and

# Authorization for Emergency Medical Treatment

*We would appreciate your help in updating your child’s health and emergency information* ***each school year*** *so that we can take the best possible care of him/her at school. Please fill out this information sheet, sign and return it to school.*

## Student’s Name Birth Date Sex Grade

## Parent/Legal Custodian Name and Address Daytime Phone

## Family Doctor/Town/Phone Number Family Dentist/Town/Phone Number

### Medical Insurance company / Phone number Group / Policy Number

**STUDENT MEDICAL HISTORY:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Frequent earaches, infections, colds |  | Frequent nosebleeds |  | Heart Condition |
|  | Kidney or bladder trouble |  | Physical defects |  | Asthma |
|  | Eczema/skin trouble |  | Vision problem |  | Diabetes |
|  | Frequent headaches |  | Speech problem |  | Convulsions/ seizures |
|  | Family history of tuberculosis |  | Hearing problem |  | Allergic reaction requiring |
|  | Tuberculin test positive or treated |  | Scarlet fever, rheumatic fever |  | medication—explain below under |
|  | Mental health problem |  | Chickenpox |  | allergies section |

**Please explain special health problems:**

**ALLERGIES:**

|  |  |  |
| --- | --- | --- |
| ❑ plants | ❑ foods | ❑ bees or insect sting requiring medication |
| ❑ drugs | ❑ animals | ❑ other |

Please describe the allergic **reaction** and **treatment**;

Do your child’s health problems affect his/her daily living or school participation: YES NO ***If YES, please explain***:

List and give any significant, injuries, deformities or operations:

Is child required to take medication or treatments **regularly**? YES NO ***If YES, please explain:***

Does your child wear contact lenses? Glasses?

List any special needs for riding school bus:

❒ **I authorize the principal or his/her designee to transport and seek emergency medical or dental treatment** when the need for such treatment is immediate and when efforts to contact me are unsuccessful. This authorization shall remain effective for the full school year unless revoked in writing and delivered to the Methow Valley School District. I understand that the Methow Valley School District, its employees and its Board of Directors assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of EMS transportation, hospitalization, examination, x-ray or treatment provided in relation to this authorization shall be my responsibility.

❒ **I do NOT authorize or consent to emergency medical or dental treatment for my child**. Please relate procedure to follow if child has problems, until parents can be contacted:

**Signature of parent/guardian Date**

I understand that the medical information provided above will be shared, if indicated, with those who need to know in order to provide a safe environment for my child.

I understand that the Methow Valley School District does NOT provide accident medical insurance for students for school-related injuries, but does offer student accident insurance for voluntary purchase. I have received the information and application for this program. I ❒will ❒will not enroll my child in the program.

***Expires at end of current school year.***   **Signature of parent/guardian Date**