

FORT ZUMWALT SCHOOL DISTRICT STUDENT HEALTH INVENTORY and HEALTH CARE CONSENT

Student: _____
Last
First
M.I.

School: _____ Grade: _____ Date of Birth: _____

Sex: M F

Check all that apply to your child:

| | | | |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> ADD / ADHD | Medication? <input type="checkbox"/> | Specify Med: _____ | |
| <input type="checkbox"/> Allergies, food | Epi Pen? <input type="checkbox"/> | Specify Food: _____ | ***Additional forms required |
| <input type="checkbox"/> Allergies, insects | Epi Pen? <input type="checkbox"/> | | ***Additional forms required |
| <input type="checkbox"/> Allergic Reaction to Medications | | | |
| <input type="checkbox"/> Allergies, other | Specify: _____ | | |
| <input type="checkbox"/> Asthma: | Medication? <input type="checkbox"/> | Specify Med: _____ | ***Additional forms required |
| <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe | | | |
| <input type="checkbox"/> Diabetes - Please provide Dr. contact information: | ***Additional forms required | | |
| <input type="checkbox"/> Does your child use hearing aides or have a cochlear implant? | | | |
| Additional Information: | | | |
| <input type="checkbox"/> Does your child wear glasses or contacts? | Fulltime <input type="checkbox"/> | Just for reading <input type="checkbox"/> | |
| Additional Information: | | | |
| <input type="checkbox"/> Epilepsy / seizures | Additional Information: _____ | | ***Additional forms required |
| <input type="checkbox"/> Heart condition / disease | Additional Information: _____ | | |
| <input type="checkbox"/> Mental / emotional condition | Additional Information: _____ | | |
| Under care of mental health professional? <input type="checkbox"/> Name: _____ | | | |
| <input type="checkbox"/> Migraines | Medication? <input type="checkbox"/> | Specify Med: _____ | Bring to school <input type="checkbox"/> |
| <input type="checkbox"/> Neurological Disorder | Specify: _____ | | |
| <input type="checkbox"/> Skin condition | Specify: _____ | | |
| <input type="checkbox"/> Orthopedic problems | Specify: _____ | | |
| <input type="checkbox"/> Wheelchair <input type="checkbox"/> Leg braces <input type="checkbox"/> Walker | | | |

By signing this form, I give school permission to treat my child for minor illness, injury while at school, using the OTC products listed on the Health Care form available in my packet and on the District web site.

Ft. Zumwalt will provide routine vision and/or hearing screenings for all students in grades K – 5 and grade 7.
COMPLETE AND SIGN ON REVERSE SIDE

**District policy requires a doctor's signed, written request for administration of prescription medication.*

| | | | |
|---|--------------|-----------|-------------------------------------|
| MEDICATIONS: taken at school? Please list: | | | ***Additional forms required |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| MEDICATIONS: taken at home? Please list dosage and times: | | | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| Has your child had a recent serious illness/hospitalization? | | | |
| Specify: _____ | | | |
| | | | |
| Does your child need: | | | |
| <input type="checkbox"/> Restricted physical education (need Dr. note) | | | |
| <input type="checkbox"/> Special seating | | | |
| | | | |
| Other conditions the school should be aware of: | | | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| Local Physician's name & telephone number | | | |
| _____ | | | |
| Name | Address | Telephone | |
| <i>In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me I hereby authorize the school to take the steps necessary to insure the well being of the above-named child, which may include calling 911. If the parent(s)/guardian(s) cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parent(s)/guardian(s). This information is confidential and will be shared with school personnel when deemed necessary.</i> | | | |
| NOTE: Please keep the office informed of current emergency contact information. | | | |
| _____ | | _____ | _____ |
| Signature of Parent / Guardian (Required) | Relationship | Date | |
| <i>By signing this form, I give school permission to treat my child for minor illness, injury while at school, using the OTC products listed on the Health Care form available in my packet and on the District web site.</i> | | | |

You will be requested to complete and update the Student Health Information and Health Care Consent form annually.